NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	11	Enclosure Number:	06a
Date	10 November 2022		
Title	Findings and our response to the Independent Investigation into East Kent Maternity and Neonatal Services		
Authors/Sponsoring Director/Presenter	Suzie Cro, Deputy Director of Quality, Lisa Stephens, Head of Midwifery, Simon Pirie, Chief of Service Matt Holdaway, Chief Nurse and Director of Quality		

Purpose of Report		Tick all that apply ✓	
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Situation

On the 20 October 2022 NHS England sent a letter to all Trusts and ICBs after the publication of the Independent Investigation into East Kent Maternity and Neonatal Services Report - "Reading the Signals" (appendix 1). The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families receiving care at East Kent Hospitals University NHS Foundation Trust. The expectation is that every Trust and ICB review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'. The purpose of this presentation is to provide assurance that we have mechanisms in place to review the report in detail, to respond to the findings and to make a plan for improvements.

Background

Following concerns raised about the quality and outcomes of maternity and neonatal care, at East Kent NHSE commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services. Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

Assessment

The attached presentation shows where we are as an organisation and our initial plans for improvement against the four areas for action.

The four areas for improvement are:

1. Monitoring safe performance; finding signals amongst the noise

2. Standards of clinical behaviour; technical care is not enough

3. Flawed team working; pulling in different directions

4. Organisational behaviour; looking good while doing badly

Summary

We have extensive improvement plans within our maternity and neonatal services and we will use this this report as an opportunity to check in that we have put the right improvements in place. As an organisation, we will

continue to improve our maternity and neonatal services by listening, understanding and responding to the experience of women, babies and families who use our services. We will continue to examine the culture within our maternity and neonatal services and improve how we listen and respond to staff. We will take steps to assure ourselves, and the communities we serve, that the leadership and culture across our maternity and neonatal service positively supports the care and experience we provide. We will work very closely on our improvement programme with our colleagues in the Gloucestershire Integrated Care Board (ICB) and within the Local Maternity and Neonatal System (LMNS).

Recommendation

The Board is asked to:

- note the next steps for our maternity services as we work with the ICB/LMNS to respond fully to this report
- note that NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and the implications.
- note that in 2023, NHSE will publish a single delivery plan for maternity and neonatal care which will bring together the action required following the East Kent Report, The Shrewsbury and Telford Report (Ockendon 1 and 2).

Enclosures

- The findings and our initial response to the "Reading the Signals Report"
- NHSE letter dated 20 October 2022
- Link to **Reading the signals** Maternity and neonatal services in East Kent – the Report of the Independent Investigation

Gloucestershire Hospitals
NHS Foundation Trust

Independent Investigation into East Kent Maternity and Neonatal Services

"Reading the Signals"

1 November 2022

Chief Nurse & Director of Quality - Matt Holdaway
Deputy Director of Quality – Suzie Cro
Lisa Stephens – Head of Midwifery
Simon Pirie – Chief of Service

Situation

- The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families.
- Outlines problems at every level - failures to listen and in teamworking, professionalism, compassion, following safety incidents and in the Trust's response including Trust Board and at regulatory level
- This report reconfirms the requirement for Board to remain focused on delivering personalised and safe maternity and neonatal care.
- Service users must be listened to, understood and responded to with respect, compassion and kindness.

Background

"Reading the Signals"

- Morecambe Bay
- Ockendon 1 and final report (Shrewsbury and Telford)
- Nottingham currently now being reviewed

Our initial assessment

Area for action	Where we are now	Next steps
1. Monitoring safe performance – finding signals amongst the noise	- Concerns about performance of maternity service triggered a series of internal actions (independent review, secondment of individual, executive led Maternity Delivery Group set up (2021 - Safe and well led rated by CQC as inadequate (July 2022) - S29A warning notice - Sharing improvement action plan with LMNS, ICB and CQC (Oct 2022) - Review of maternity metrics on Board QPR (current) - Perinatal Quality Surveillance (PQS) Report presented to Board (Oct 2022) - Board level Safety Champions programme of work - Regional NHSE/LMNS/MVP Insights visit July for the embedding of Ockendon – 7IEA's - NHSE National Team Maternity Safety Improvement Programme diagnostic review underway - Speciality Tri oversight and monitoring of maternity scorecard and assurance dashboard - External expert opinion pathway in place for external review of all SI's - MOU with Buddy LMNS BSW – Joint Safety Forum established to share learning and benchmark outcomes	- The Badgernet digital system will enable data for audit - Continue to provide PQS Report quarterly and develop with feedback from Board/LMNS - Await report from the NHSE Maternity Safety Improvement programme (diagnostic visit) - Await formal feedbackand recommendations from Insights visit - Working on action tracker against 15IEA's ahead of publication of single delivery plan for maternity and neonatal services - Review NHSR Scorecard data- triangulation – incidents, complaints and claims

Our initial assessment

Gloucestershire Hospitals NHS Foundation Trust

Area for action	Where we are now	Next steps
2. Standards of clinical behaviour - technical care is not enough	- CQC Caring domain remains rated as good - Positive patient experience results when benchmarked with other Trusts - Complaints data presented in PQS Report - Culture picked up on as an area for improvement by CQC and so cultural improvement plan being developed - Review of data and plan - Engagement with the 'RCOG Roles and Responsibilities of the Consultant' document	- Just and restorative culture improvement work - Respectful resolution tools to be embedded with Maternity Leadership and OD Specialist - Repeat of SCORE survey planned by national team - Specialty Tri analysis of patient feedback

Our initial assessment

Gloucestershire Hospitals NHS Foundation Trust

Area for action	Where we are now	Next steps
3. Flawed team working - pulling in different directions	- Developing common purpose with Maternity Service strategy - engagement with teams - Staffing updates for midwifery and obstetrics at every MDG meeting - Workforce Report to Board 6 monthly - Revitalising the Professional Midwifery Advocacy (PMA) Service - Training needs analysis in development for all staff - Engagement with national Staff Survey - Multiprofessional training for PROMPT	- Review Staff Survey results for maternity in Jan 2023 - Development of Workforce Strategy Explore and deliver team working development opportunities with Leadership and OD Specialist - National Leadership Development Programme – Quadumvirate leadership programme

Our initial assessment

Gloucestershire Hospitals NHS Foundation Trust

Area for action	Where we are now	Next steps
4. Organisational behaviour – looking good while doing badly	- Trust risk register entry for midwifery staffing (scoring at 20 for safety) - CQC S29a warning notice improvement plan – check and challenge process with LMNS/ICB/CQC - CQC Must do and Should do action plan - Single site Local Maternity and Neonatal System - Engagement with the NHSE National Maternity Safety Improvement Programme (MSIP) diagnostic phase report due now	- Engaged with other organisations in neighbouring LMNS for learning and sharing - NHSE Regional Maternity InsIghts Report due end of November/early Dec - NHSE National MSIP report 4-6 weeks

Recommended actions

- NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and the implications.
- In 2023, NHSE will publish a single delivery plan for maternity and neonatal care which will bring together the action required following the East Kent Report, The Shrewsbury and Telford Report (Ockendon 1 and 2).
- We ask the Trust Board to note the next steps for maternity services as we work with the LMNS to respond to this report.

Classification: Official

Publication reference: PR2099

To:
- Trust Chief Executives
- Trust Chairs
- ICB Chief Executives
- LMNS Chairs

cc.
- Regional Directors
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief Midwives
- Regional Obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 October 2022

Dear colleagues

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Yesterday saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units

- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**06b**
Date	10 November 2022		
Title	Maternity Services Perinatal Quality Surveillance and Safety Report Quarter 2 (Maternity Incentive Scheme Compliance CNST)		
Author /Sponsoring Director/Presenter	Josette Jones, Women's and Children's Lead for Quality and Governance Matt Holdaway, Chief Nurse and Director of Quality		

Purpose of Report		Tick all that apply ✓	
To provide assurance	**x**	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	**x**
To canvas opinion		**For information**	**x**
To provide advice		**To highlight patient or staff experience**	

Summary of Report

In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of July - September 2022 – quarter 2 (Q2).

Summary

National Events, Regulatory and NHSE/I Reviews

- Following the CQC unannounced focused inspection in Q1 and the subsequent Section 29a warning notice the service received the final report in Q2. Work on these improvements was started immediately and continues to be actioned. Within the final report there were 4 must do and 8 should do actions which are progressing. The service developed a maternity scorecard in addition to the metrics collected on the perinatal dashboard to monitor items of concern from the CQC report and also compliance with the Maternity Incentive Scheme. The S29a action plan in on track to close at the end of December 2022.
- On September 26th and 27th The NHSE/I Regional Team came and did an Insights Visit to do an assurance check on the progress against the first Ockendon report. The NHSE/I Team agreed that there were 2, out of 7 actions that remained amber (partially completed). The feedback included that the maternity staff were tired but also very caring.
- Three NHSE/I National Team Maternity Improvement Advisors visited to commence the diagnostic part of the programme on September 27th and 28th. On conclusion of their visit they made 3 safety recommendation for the Service to act upon and a report will be provided to the Trust in the next 3-4 weeks.

Learning from deaths – maternal, perinatal and neonatal mortality

- There were 6 early neonatal deaths 1 of which occurred at Bristol All babies were premature including a 22+6 week baby where the baby breathed following delivery and the parents requested full resuscitation. Premature twins were also born at 19+6 weeks showing signs of life with no neonatal intervention due to extreme prematurity.
- There were 2 maternal deaths both reported to HSIB for investigation. Both cases occurred in the community and attributed to pulmonary embolism.
- There were 4 stillbirths in Q2 including an intrapartum stillbirth following delay in on going induction of labour – meeting HSIB criteria and appropriately referred for review.

- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.

Maternity training compliance

Mandatory maternity training compliance for the core competence framework is flagging as an issue and is below the required target for all staff groups (target set is 90%) following an update to the Maternity Incentive Scheme in October 2022. An additional fetal monitoring day is planned and a review of PROMPT compliance will be undertaken and an additional date added if required paying staff bank hours to attend in their own time.

Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register now scoring 20 (WC35360bs).
- A maternity workforce paper is due to be reviewed by Board in November 2022.
- Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. There is a plan to review this at the beginning of the New Year.
- Postnatal beds at Stroud have also been temporarily closed and will be reviewed weekly.
- There were no rota gaps in the Obstetric cover.

Maternity Service user feedback

- Friends and Family Test scores has improved to at 93% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response

Staff feedback to Maternity and Neonatal Safety Champions (MNSCs)

Staff have fed back no safety concerns however discussions around the digital system Badgernet and frustration of it not being in place. Discussions on Aveta unit of how proud staff were of their service and noting the impact when the unit closes although the midwives understood the reason why it did close.

Clinical Incident Reporting

A total of 8 cases were scoped:
Six met HSIB referral criteria – (1 of which was rejected – the baby had a normal MRI and was a no harm; 1 of which is a maternal death reported to HSIB by North Bristol Trust as the woman was taken there by HEMS so a joint review of care with NBT).

- 1 case Serious Incident panel awaiting further information
- 1 incident was graded as no harm
- 4 investigations are being carried out by HSIB currently.
- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- There were no Prevention of Future Death Reports (Coroner regulation 28).

Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75%.
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all

Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.

- In May, the Trust received notification of the unpausing of the scheme and a revised list of safety actions was circulated (appendix 1). Some criteria changed and work commenced to adapt to these modifications to the scheme.
- In October 2022, the scheme was updated again and a review of the requirements is on going particularly with regards to safety action 8
- Safety action 6 of the MIS includes CO monitoring at booking and 36 weeks gestation. Due to the inability to record the 36 reading on Trak a paper audit of all women is being undertaken by the service. This is further hindered by a lack of working equipment for a 2-month period resulting in the inability to undertake this assessment until August 2022. Audit has now commenced but is labour intense due to the number of notes required to review.

Recommendation

The Board is asked to note the contents of the report.

Enclosures

Perinatal Quality Surveillance and Safety Report Quarter 2

Gloucestershire Hospitals
NHS Foundation Trust

Maternity Service
Perinatal Quality Surveillance and Safety Report (Maternity Incentive Scheme Compliance – CNST)

Quarter 2 July –September 2022/23

Author:
Women's and Children's Lead for Quality and Governance - Jossette Jones

Executive sponsor:
Director of Quality and Chief Nurse, Matt Holdaway
Executive Maternity and Neonatal Safety Champion

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Gloucestershire Hospitals NHS Foundation Trust

Perinatal Quality Dashboard – trend data

Gloucestershire Hospitals NHS Foundation Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Good	Good	Good

CQC inspection April 2022 Section 29a and draft report received June 2022

Maternity Safety Support Programme	No	If No, enter name of MIA

	2021/22											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Findings of review of all perinatal deaths using the real time data monitoring tool	4	1	2	1	2	3	1	1	4	2	3	3
Findings of review all cases eligible for referral to HSIB.	1	1	1	1	0	1 (rejected)	0	1	1			
The number of incidents logged graded as moderate or above and what actions are being taken	2 (1 HSIB SI; 1 Moderate)	1 HSIB	2 SI (1 HSIB)	2 SI (1HSIB)	0	0	2 SI (1HSIB). 1 Moderate (joint GYN/Obs)	0	0	1	1	2
Maternity PROMPT Skills Drills							35.50%		62.50%			
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training		83% Trust target 90%	81% Trust target 90%		83%	81%	80%	79%	81%	81%	83%	82%
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite & gaps in rotas		0 gaps in rota. Locum shifts covered: 5 SHO, 18 Registrar	0 gaps in rota. Locum shifts covered: 10 SHO, 28 Registrar	0 gaps in rota. Locum shifts covered: 8 SHO; 22 Registrar	0 gaps in rota. Locum shifts covered: 4 SHO; 17 Registrar	0 gaps in rota. Locum shifts covered: 5 SHO; 17 Registrar	0 gaps in rota. Locum shifts Reg 31; 2 SHO	0 gaps in rota. Locum shifts 28; SHO 1	0 gaps in rota. Locum Reg 31; SHO 0			
Minimum safe staffing in maternity services to include midwife minimum safe staffing planned cover versus actual prospectively.	**All clinical areas: A total of 97 unfulfilled midwifery shifts, 50 MCA, 13 housekeepers**	**All clinical areas: A total of 98 unfulfilled midwifery shifts, 48 MCA, 1 band 7 co-ordinator in charge shift**	**All clinical areas: A total of 134 unfulfilled midwifery shifts, 49 MCA, 7 band 7 co-ordinator in charge shift**	**All clinical areas: A total of 154 unfulfilled midwifery shifts, 59 MCA, 7 band 7 co-ordinator in charge shift**	**All clinical areas: A total of 126 unfulfilled midwifery shifts, 23 MCA**	**All clinical areas: A total of 72 unfulfilled midwifery shifts, 38 MCA**						
Service User Voice feedback	81.2	89.90%	84.30%	94.10%	91.90%	85.70%	78.20%	85.20%	88.90%	91.80%	79.50%	93.00%
Staff feedback from frontline champions and walk-abouts	nil	nil	nil	nil	nil	nil			IT & Aveta			
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	nil	nil	nil	nil	nil	nil	nil	Section 29a	Section 29a	Section 29a	Section 29a	Section 29a
Coroner Reg 28 made directly to Trust	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	75% (Divisional total nursing and midwifery
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	Reported from 2019 results 87.5%. National average 89.54%

BOARD November 2022

REPORT ON THE SAFETY OF MATERNITY SERVICES

Perinatal Quality and Safety Report – Quarter 2 2022/23

1. Purpose of report

1.1 In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of July to September 2022 – quarter 2 (Q2).

2. Perinatal quality surveillance narrative summary and exception report Q2

2.1 Maternity Perinatal Quality Surveillance Q2 narrative (see dashboard for data).

2.1.1 National Events, Regulatory and NHSE/I Reviews

CQC

- On 6 & 7 April 2022 **CQC** carried out an unannounced focused inspection within the Maternity service, as they had received information giving them concerns about the culture, safety, and quality of the services. As this was a focused inspection, they only inspected safe, well-led and parts of the effective Domains key questions. Following the inspection, they made requests for additional data and spoke to a number of staff after the on-site inspection. The service was then issued a Section 29a warning notice around improvements required to safety, leadership and governance in May 2022. Work on these improvements was started immediately and continues to be actioned. The service developed a maternity scorecard in addition to the metrics collected on the perinatal dashboard to monitor items of concern from the CQC report and also compliance with the Maternity Incentive Scheme. The S29a action plan in on track to close at the end of December 2022.

Table CQC Dashboard

MEASURE	Apr	May	Jun	Jul	Aug	Sep	Sparkline
MOEWS				69%	82%		
MOEWS Charts Completed & Escalated							
Safe to Respond				74%	88%	93%	
L3 Safeguarding Training Compliance			57%	62%	59%	56%	
Elearning Compliance	80%	79%	81%	81%	83%	82%	
Appraisal Compliance	60%	60%	59%	60%	69%	62%	
Maternity Mandatory Training						79.50%	
Overdue incidents			22	80	26	44	
Overdue Actions		19	22	17	11	10	
CO Monitoring at 36/40			58.40%	68.90%			
PMA RCS Sessions				6	9		
NEWTT		95%		100%			
WHO							
External Opinion - Requested		2	1	1	1	3	
External Opinion - Attended		0	1	0	1	3	
Covid signage - checked Maternity Ward						51.7	

- The CQC inspection report was received during quarter 2 (July 22nd) and within the report there were 4 Must Do and 8 Should Do actions for the service which are being actioned.

NHSE – Insights Visit

- On September 26th and 27th The NHSE/I Regional Team came and did an Insights Visit to do an assurance check on the progress against the first Ockendon report. The NHSE/I Team agreed that there were 2, out of 7 actions that remained amber (partially completed). The feedback included that the maternity staff were tired but also very caring.

NHS Resolution

- Following the findings of the CQC report NHS Resolution have requested that the Trust review certain elements of their submission for years 3 & 2 and to reaffirm that they met criteria

2.1.2 NHSE/I Maternity Safety Support Programme

- The service will commence on the NHSE/I Safety Support Programme as the Trust have received a CQC Section 29a Warning Notice and the organisation has received a letter outlining the support offer.
- Three NHSE/I National Team Maternity Improvement Advisors visited to commence the diagnostic part of the programme on September 27th and 28th.

Table: Phases of the MSIP

Phases	Date	Actions
Programme initiation	21 June 2022 7 Oct 2022	Letter received and Trust to commence programme because of the inadequate rating Meeting with the National Team to commence the programme
Diagnostic phase	27,28,29 Sept 2022	3 Maternity Improvement Advisors on site. 3 immediate safety recommendations made and actioned
Implementation phase		**Report due 3-4 weeks**
Improvement phase		
Sustainability phase		
Exit from programme		Rating by CQC “Good”

- On conclusion of their visit they made 3 safety recommendation for the Service to act upon (see table below) and a report will be provided to the Trust in the next 3-4 weeks.

Table: Immediate Safety Actions recommended after the diagnostic visit

Immediate Safety Recommendation	Actions taken
1. Undertaking CTGs in the Birth Centres	CTG machines removed whilst understanding the system for when their use would be appropriate (for example at the Consultant Clinic).
2. “Triage”/ antenatal	Women being seen as an alternative to travelling to GRH Triage. Current practice to be reviewed and the

assessments in Birth Centres	criteria and pathways need to be clear.
3. 1:1 care in labour in Birth Centres	When there is a woman in labour there needs to be a 2nd midwife caring for the postnatal women. Stroud Postnatal beds are temporarily closed to support this, due to the current staffing challenges and this will enable a review of the model of care.

- The NHSE/I self- assessment tool review has been repeated for August and we are using this tool to inform our maternity quality improvement and safety plan, and so to keep the trust board and LMNS aware of our 'benchmarked' position.

Table: NHSE/I Self-assessment compliance – August 2022

Self-assessed compliance	**16 Feb 2022**	**May 2022**	**August 2022**
Green	111	105	91
Amber	44	44	47
Red	5	11	22
Total number of elements	160	160	160

2.1.3 Learning from deaths – maternal, perinatal and neonatal mortality

- There were 6 early neonatal deaths 1 of which occurred at Bristol (specialist care required due to extreme prematurity). All babies were premature including a 22+6 week baby where the baby breathed following delivery and the parents requested full resuscitation. Premature twins were also born at 19+6 weeks showing signs of life with no neonatal intervention due to extreme prematurity.
- There were 2 maternal deaths both reported to HSIB for investigation. Both cases occurred in the community and attributed to pulmonary embolism.
- There were 4 stillbirths in Q2 including an intrapartum stillbirth following delay in on going induction of labour – meeting HSIB criteria and appropriately referred for review.
- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.
- See also NHS Resolution (NHSR) safety action 1 for more information at appendix 2.

2.1.4 Maternity training compliance

- The NHS Resolution Maternity Incentive Scheme was updated in October. Although this report refers to Q2 the implications of the changed to safety action 8 Mandatory maternity training has meant that compliance for the core competence framework can now only be counted for a 12-month period between August 2021 and December 5th 2022 rather than the whole period. Recalculations have been undertaken for all staff groups required to attend and compliance recalculated. Current compliance below the target of 90% with a further training date in November. An additional fetal monitoring day is planned and a review of PROMPT compliance will be undertaken and an additional date added if required paying staff bank hours to attend in their own time
- See also NHSR safety action 8 for more information at appendix 2.

2.1.5 Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register now scoring 20 (WC35360bs).
- A maternity workforce paper is due to be reviewed by Board in November 2022.
- Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. There is a plan to review this at the beginning of the New Year.
- Postnatal beds at Stroud have also been temporarily closed and will be reviewed weekly.
- There were no rota gaps in the Obstetric cover.
- See also NHSR safety action 4 & 5 for more information appendix 2.

2.1.6 Maternity Service user feedback

- Friends and Family Test scores has improved to at 93% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response.
- See also NHSR safety action 7 for more information appendix 2.

2.1.7 Staff feedback to Maternity Service Champions

- Staff have fed back no safety concerns however discussions around the digital system Badgernet and frustration of it not being in place. Discussions on Aveta unit of how proud staff were of their service and noting the impact when the unit closes although the midwives understood the reason why it did close.
- See also NHSR safety action 10 for more information at appendix 2.

2.1.8 Clinical Incident Reporting

- **A total of 8 cases were scoped:**
  - 6 met HSIB referral criteria – (1 of which was rejected – the baby had a normal MRI and was a no harm; 1 of which is a maternal death reported to HSIB by North Bristol Trust as the woman was taken there by HEMS so a joint review of care with NBT)
  - 1 case Serious Incident panel awaiting further information
  - 1 incident was graded as no harm

- 4 investigations are being carried out by HSIB currently.
- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- There were no Prevention of Future Death Reports (Coroner regulation 28).
- See also NHSR safety action 10 for more information appendix 2.

2.1.9 Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75% (Staff Survey 2022).
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

2.1.10 Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.

- In May, the Trust received notification of the unpausing of the scheme and a revised list of safety actions was circulated (appendix 1). Some criteria changed and work commenced to adapt to these modifications to the scheme.
- In October 2022, the scheme was updated again and a review of the requirements is on going particularly with regards to safety action 8
- Safety action 6 of the MIS includes CO monitoring at booking and 36 weeks gestation. Due to the inability to record the 36 reading on Trak a paper audit of all women is being undertaken by the service. This is further hindered by a lack of working equipment for a 2-month period resulting in the inability to undertake this assessment until August 2022. Audit has now commenced but is labour intense due to the number of notes required to review.

  Safety Actions progress can be seen at appendix 2
  Action 1 National Perinatal Mortality Review Tool
  Action 2 Maternity Service Data Set (MSDS)
  Action 3 Transitional Care Services in place
  Action 4 Workforce planning in place to the required standards
  Action 5 Midwifery workforce planning in place
  Action 6 Saving babies lives care bundle (SBLCBv2)
  Action 7 Service user feedback and work with MVP to coproduce maternity services
  Action 8 Local training plan in place to meet all 6 core modules of the core competency framework
  Action 9 Maternity Safety Champions
  Action 10 HSIB and NHSR reporting

3 Recommendation

The Maternity Delivery Group, Quality and Performance Committee and Board are asked to note the contents of the report and support the improvement plans. This report will be submitted to the Local Maternity and Neonatal System (LMNS) for assurance.

4 Appendix 1 - Maternity Incentive Scheme (MIS) Progress Report Q1

Introduction – what are we trying to accomplish?
Maternity incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. NHS Resolution support this work through the Maternity Incentive Scheme. The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. In the fourth year, the scheme further incentivises the 10 maternity safety actions from the previous year with some further refinement. Year four of the scheme began on 9 August 2021.

Due to the Covid-19 pandemic, in December 2021, a decision was made by the scheme's Clinical Advisory Group (CAG) to pause the reporting for year 4 of the scheme. Trusts were asked to continue to apply the principles of the scheme and to continue to report to MBRRACE-UK, NHS Digital and HSIB. The scheme's CAG reconvened on 28 February 2022 and a decision was made to relaunch the scheme on 6 May 2022. A further updated version of the scheme was published in October 2022

How will we know if a change is an improvement?
As in year three, the scheme incentivises ten maternity safety actions. We need to demonstrate that we have achieved all of the ten safety actions so that we will recover the element of our contribution to the CNST maternity incentive fund and so that we can also receive a share of any unallocated funds.
Whilst the maternity incentive scheme is a self-certified scheme, with all scheme submissions requiring sign-off by our trust Board following conversations with trust commissioners, all submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC). The Trust must submit our completed declaration by 2nd February 2023 (new date). This section updates our progress so far.

Table: Progress summary of all 10 safety actions following updated October 2022 version

Action	RAG Rating and current position	Actions required
Action 1 using the National Perinatal Mortality Review Tool	a) i 100% of perinatal deaths are notified within 7 working days and the surveillance form is completed within 1 month ii 95% of reviews are commenced within 2 months. b) At least 50% of deaths are reviewed with the PMRT by MDT c) 95% of parents have been told that a review will take place and that their perspective has been considered. d) Quarterly reports have been received by the Board from 6 May onwards and the reports have been discussed with the maternity safety champions	Quarterly reports to be received by Maternity Safety Champions and Trust board from 6 May 2022 onwards (add to MSC and Board planner).
Action 2 submitting data to the Maternity Service Data Set (MSDS)	By 31st Oct 2022 Trust to have up to date digital strategy for our maternity service which aligns with the Trusts Digital strategy and reflects the 7 success measures and has been signed off by the LMNS.	The Maternity Service Digital strategy has been drafted and will be signed off by the LMNS and Divisional Board by end October. This CQIMs data will be added to the

Action	RAG Rating and current position	Actions required
	9/11 Clinical Quality Improvement Metrics (CQIMs) will have passed the associated data quality criteria in July 2022 (published Oct 2022.	QPR and the Maternity Service dashboard and be shared with MDG/MSCs. Trust Board to confirm that they have passed the data quality criteria by self-declaration (the data will be published in the Maternity Services Monthly Statistics publication in Oct 2022).
Action 3 Transitional Care Services in place	Atain reports received by Board Level Maternity Safety Champions.	Quarterly reports to be received by the Maternity Safety Champions meeting that meet all the correct defined criteria and action plans are developed for any metrics not meeting targets.
Action 4 Workforce planning in place to the required standards	On track report received by March Board 2022 and to be presented again in November 2022 (once RCOG staffing audit completed)	Board report received at March 2022 meeting and next report due November 2022. Audit to be completed on Consultant attendance in specified circumstances
Action 5 Midwifery workforce planning in place	On track - staffing report received by March 2022 Board and Birth rate plus review underway	Board report received at March 2022 meeting and next report due November 2022.
Action 6 The 5 elements of the saving babies lives care bundle have been implemented	The quarterly care bundle surveys are being completed and the service has fully implemented SBLv2 including the data submission requirements. Our current data does not meet target compliance in elements 1-4 we are not meeting the minimum requirements and no action plans have been received by MDG. An action plan will be submitted to MDG	Trust will fail Safety Action 6 if the process indicator metric compliance is less than target and there are no action plans in place. Element 1-4 are amber rated and require action plans Element 1 – CO monitoring at 36/40 difficult to achieve due to the inability to pull data from Trak and requires manual notes audit. CO monitors were not available for a number of months due to the equipment coming to end of life and new equipment was purchased. This has now been completed but the restarting of the programme needs embedding. Notes audit has commenced to demonstrate compliance. The latest version requires 60 consecutive womens notes audit. This is underway. the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement (Element 5 – is green and meeting target compliance).
Action 7 mechanisms for gathering service user feedback and work with Maternity Voices Partnership (MVP) to coproduce maternity services	MVP meetings are going ahead. MVP has a work programme Monitor MVP chair is invited to attend Maternity Clinical Governance meeting (MCG) EM Improvement plan Complaints are shared with MVP.	MDG to seek assurance that MVP Chair attending MCG – invited but unable to attend meetings on a Friday. Minutes to be shared with MVP Chair MDG to see the Ethnic Minorities improvement plan. Check complaints are shared with MVP.
Action 8 local training plan in place to meet all 6 core modules of the core competency	**Training compliance decreased to 62% (compliance target is 90%)** Local training plan includes all six core	Educational review taking place and should include the plans for the remaining 2 components of the CCF

Action	RAG Rating and current position	Actions required
framework	modules of the Core Competency Framework (CCF) 1. Saving Babies Lives Care Bundle 2. Fetal surveillance in labour 3. Maternity emergencies and multi-professional training. 4. Personalised care 5. Care during labour and the immediate postnatal period 6. Neonatal life support Training compliance has decreased due to sessions being cancelled and Midwives only being able to attend if undertaken as bank payment rather than as part of substantive hours; reduction in staffing in Practice development due to leavers. Band 6 hours recruited into both substantively and as a 6 month secondment to provide some additional hours. Band 6 PDM released into posts. However, one of the 2 midwives was successfully appointed into the 0.5WTE Band 7 job share position for |PDM which has resulted in a gap in overall hours again. Recruitment into these hours will commence in the autumn to minimise the loss of clinical staff.	- Personalised care - Care during labour Training compliance to be 90% by 5th Dec 2022 (CNST will measure compliance over any 12 month period between August 21 and 5th Dec 22). The Trust are utilising data 23rd Nov 2021 – 23rd Nov 2022 EWS (MEOWs and NEWTT) audits have been completed and a new monthly audit is sin place.
Action 9 Trust maternity Safety Champions are meeting bi monthly with the Board level champions	Safety intelligence pathway from ward to Board needs refresh to include **Perinatal Quality Surveillance** Model Report. Board level maternity service champions to present local PQS report and dashboard to Board quarterly. MCoC action plan to be reviewed by MSCs (paused/reviewed due to Covid and Ockendon 2022 IEAs) Oversight of the Neonatal Critical Care Recommendations Maternity Safety culture measurements and improvement plan. Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended	Structure for Maternity reporting ward to Board to be reviewed by MSC meeting. Quarterly PQS Reports and dashboard to be presented to the Board by the Board MSC from June 2022 (this report) To include - SIs - Claims data - Walkabout data - Training compliance - Staffing - MatNeoSiP MSCs to have at least quarterly engagement meetings MSCs to review Midwifery Continuity of Care action plan MSC to review how the service is implementing the National Neonatal Critical Care Review
Action 10 Reported 100% of qualifying cases to HSIB and to NHSR	On track all cases reported.	

Table: Key for BRAG rating

Blue	Action complete and assurance provided
Red	Action not on track with major issues
Amber	Action mainly on track with some minor issues (mitigating activities should be identified)
Green	Action on track

5 Appendix 2 - NHSR MIS Safety Action Update

Safety action 1 – Perinatal Mortality Review Tool (PMRT)

The Trust has been able to continue to report to MBRRACE as advised by NHSR. All notifications are made and surveillance forms completed using the MBRRACE-UK reporting website. All (100%) of our stillbirths and early neonatal deaths are reviewed through the use of the national standardised Perinatal Mortality Review Tool (PMRT) which adopts a systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

The speciality hold a multidisciplinary Mortality and Morbidity (M&M) Reviews and also engage with the M&M reviews of cases referred to the tertiary units when necessary. Work is in progress to ensure external opinion from the Local Maternity and Neonatal System (LMNS) from Bath, Swindon and North Somerset is also available at this meeting to achieve compliance with the Ockenden (Dec 2021) Immediate and Essential Action 1. In quarter 2 GHNHSFT requested an external opinion for scoping on 5 occasions and were able to access this on 4 occasions.

Table: Numbers of deaths in Q2

Deaths	Numbers
Early neonatal	6 (1 at Bristol)
Maternal	2
Stillbirths	4

Table: Perinatal mortality reviews July - September 2022 and action plans

MAT MRN	PMRT GRADE A		PMRT GRADE B		PMRT GRADE C or D		Action plans following PMRT reviews.
	AN	PN	AN	PN	AN	PN	
July 2022							
1024038	√			*√			*The grading of 'B' relates to the intraoperative complications and return to theatre which did not contribute to the death. **Actions**: nil.
1072554		√			*C√		*Graded a 'C' and deemed a Serious Incident by the Trust owing to the fact that the triage time from arrival to initial assessment exceeded the 15 minute target. It is unknown if this would have made a difference to the outcome. **Actions**: Awaiting report from Trust Patient Safety Investigation Team.
August 2022							
4078304		√	√				*Graded a 'B' as potentially an opportunity to have identified the Polyhydramnios sooner, however this would not have made a difference to the eventual cause of death. **Action:** Consultant to liase with genetics team to obtain more information in view to offering a debrief appointment.

0732676	√	√					**Actions**: nil
0306840	√	√					**Actions**: nil
September 2022							
1149427	√	√					**Actions**: Nil.
0905951	√	√					**Actions**: Nil from Review at Perinatal Mortality Meeting. Ongoing HSIB case.
0867398	√	√					**Action**: consultant to arrange debrief appointment.

PMRT Grading: (split into antenatal and postnatal)
A. No issues with care identified
B. Care issues that would have made no difference to the outcome
C. Care issues which may have made a different to the outcome
D. Care issues which were likely to have made a difference to the outcome

Perinatal Mortality Review Tool and Trust compliance with statements

Compliance and Action Plans for PMRT for July - September (Quarter two).

Year four of the Clinical Negligence Scheme for Trusts (CNST) from: 6th May – 5th December 2022.

Safety action 1 – using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard.

a) i. 100% of perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Trust Compliance: 100%

a) ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death (100% of factual question answered). This includes deaths after home births where care was provided by your Trust. Trust Compliance: 100%

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. Trust Compliance: 100%

c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022 the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are

any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

Trust Compliance: 100% of parents. A further change has been made recently to increase the numbers of parents who contribute their questions and perspectives on their care. The MBRRACE feedback form will be sent directly from the Perinatal Review Team (Baby Loss Review Team) with a letter explaining the review and how important it is to contribute their perspectives and questions. We also send them a simple bereavement card of 'forget-me-not flowers' to add a more personal touch with a message of condolence.

Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Relevant time period 6 May 2022 – 5 December 2022.

Deadline for reporting to NHS resolution – 5 Jan 2023.

Improvement action
To meet the NHSR MIS Standard a report should be received every quarter by the Board and the report should include details of the deaths reviewed and the consequent action plans. The quarterly reports will also need to be discussed with the Maternity Safety Champions and the Board Level Safety Champions.

Safety action 2 - Maternity Service Data Set (MSDS)

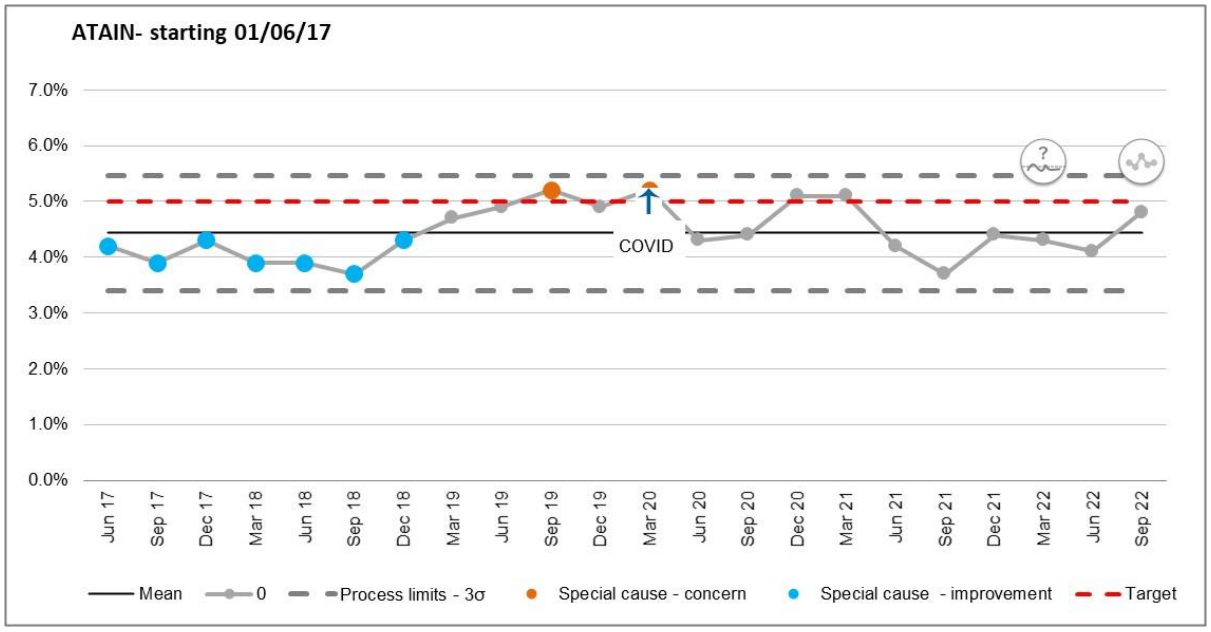
This relates to the quality and completeness of our submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. The digital strategy for is currently in draft and circulated for comments and will be approved by the Divisional Board and by the LMNS by 31st October 2022.

Improvement action
In July 2022, we will submit our data and then in Oct 2022 we will receive a file in the Maternity Services Monthly Statistics publication to confirm that we are meeting at least 9/11 Clinical Quality Improvement Metrics.

Safety action 3 - Transitional care services

Transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme. We have developed pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

Graph: Data demonstrates that we are currently below the National target of 5%



Improvement action

Progress with our ATAIN action plans will be shared with the maternity, neonatal and Board level safety champions, LMNS and our ICS quality surveillance meeting.

Safety action 4 & 5 demonstrate clinical workforce planning

The Board received a maternity workforce report in March 2022 and the next report is due in November 2022.

Maternity Unit temporary closures

There was one episode of whole unit emergency closure on July 14th during Q2, of maternity services. Due to staffing issues Aveta Birth Unit remains closed to intrapartum care; clinics and DAU work continues to operate from the freestanding birth unit during the day. This action will be reviewed in the New Year. Stroud Maternity Unit postnatal beds have been closed since 30th September and will be reviewed weekly.

Improvement action

The next Maternity Workforce report is due to be received by Board in November 2022. The Maternity Birthrate Plus review commenced in quarter 1 2022 and the report and recommendations will be received by Board within this next report.

Safety action 6 - demontrate compliance with all five elements of the Saving Babies Lives Care Bundle Version 2 (SBLCBv2)

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one. This version aims to provide detailed information on how to reduce perinatal mortality. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. The new fifth element is reducing pre-term birth. This is an additional element to the care bundle developed in response to the Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to

6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable. While the majority of women receive high quality care, there is around a 25 per cent variation in the stillbirth rates across England. The Saving Babies' Lives Care Bundle addresses this variation by bringing together five key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. Our Q2 data has been summarised in the dashboard below. Ongoing audits to demonstrate compliance being prioritised. There is no permanent audit midwife in post -work and so work is being undertaken by bank midwife. Items with 0% in black are not values but missing data whilst audits continue

Picture: SBLCBv2 dashboard

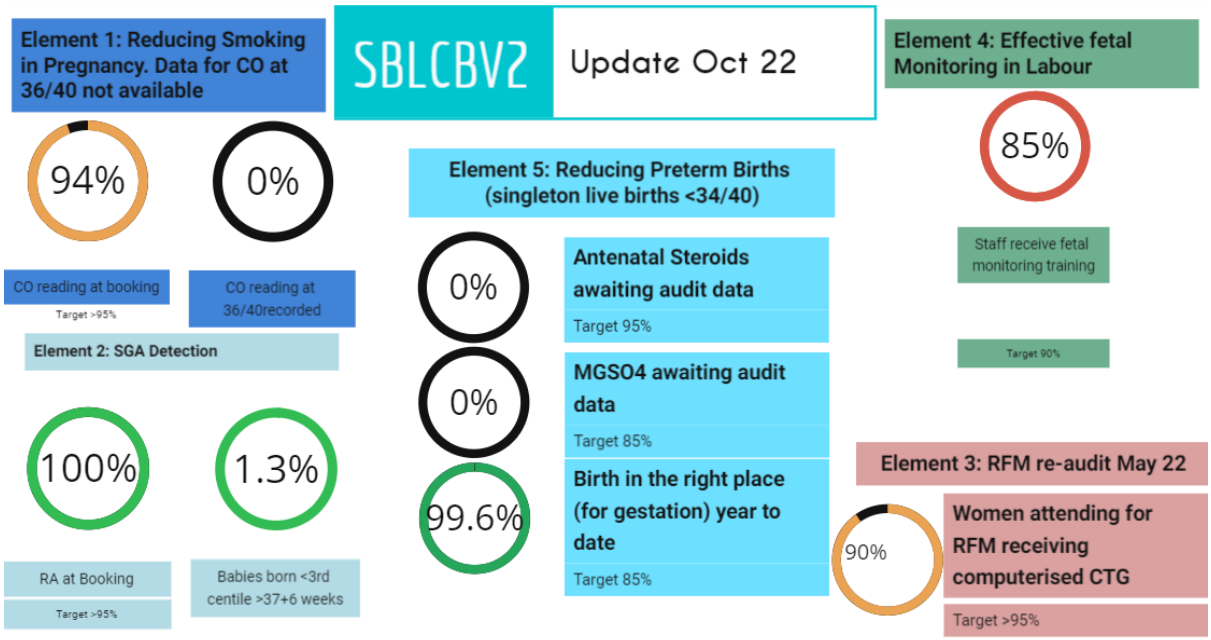


Table: SBLCBv2 element, BRAG rating and improvement plan

Element	BRAG rating	Improvement plan
Element 1 - Reducing smoking in pregnancy		CO_2 monitoring at 36/40 – data not available on Trak resulting in notes audit being undertaken. Compliance remains low on latest audit demonstrating 50% compliance. Smoking Cessation midwife working with community leads to address the issue and undetake teaching sessions locally with midwives. Replacement of CO monitors has delayed the ability to commence the audit as monitors were not available for staff to undertake the recording. These are now replaced. This also affected the compliance with CO monitoring at booking which fell to circa 60%. Latest data has now increased to 94% and the service will continue to monitor this to ensure compliance. Audit now comenced to monitor recording at 36/40 undertaking 60 sets of records.
Element 2 - Risk assessment and surveillance for fetal growth restriction		Audit completed and demonstrated 100% compliance
Element 3 – Raising awareness of reduced fetal movement		Audit demonstrates 90% compliance for computerised CTG's undertaken.

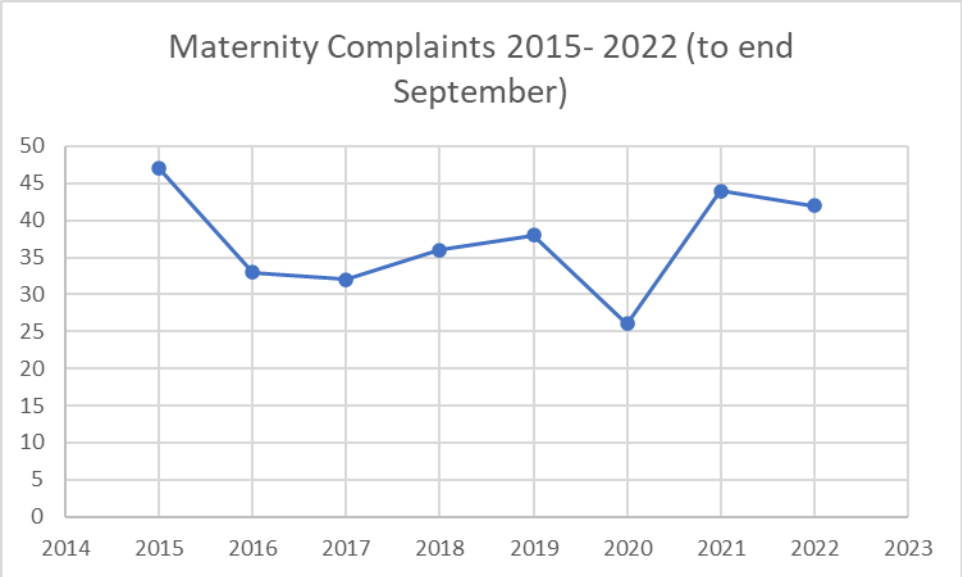
Element	BRAG rating	Improvement plan
Element 4 – Effective fetal monitoring during labour		Fetal monitoring study days now recommenced and a plan to ensure >90% compliance being developed by the leads. Current data 85% compliant for midwives and junior doctors. Consultants 90% compliant. One further data in November with a further date planned to enable more staff to attend. Staff receive training on local CTG machines.
Element 5 – Preterm care		Further audit underway to demonstrate compliance. Process indicator D 99.6% total for year to date (Q1&2). Trusts will not fail element 5 if below 80% but will recquire an action plan to achieve >80%

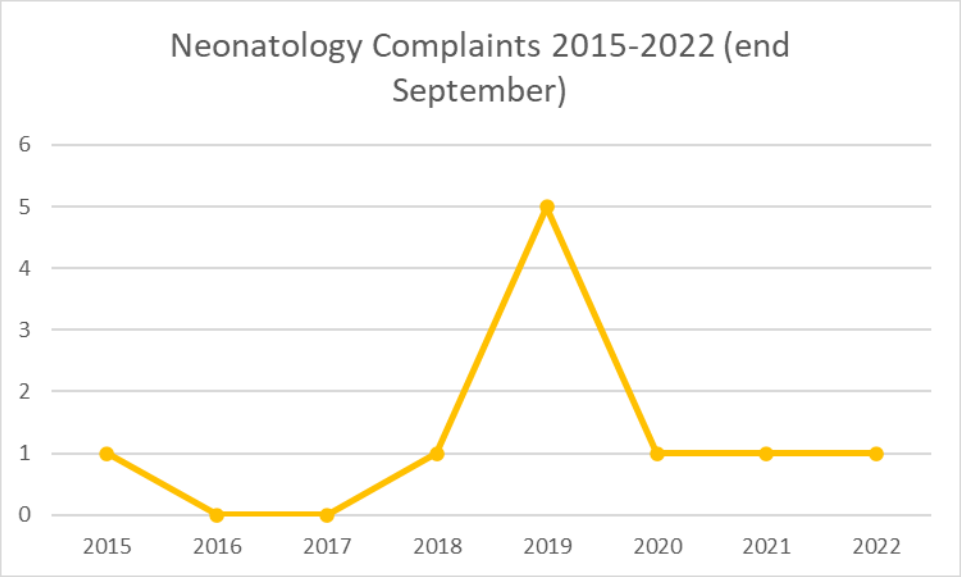
Safety action 7 - service user feedback

Complaints

The following chart displays the number of complaints for both maternity and neonatal services since 2015. There were no complaints specifically attributed to Covid although it should be acknowledged that staffing factors and service delivery alterations throughout the pandemic will have impacted on the level and category of complaints received. There was a total of 16 complaints for the maternity service in Q2 a 14% increase from Q1.

Table: Total number of complaints by year



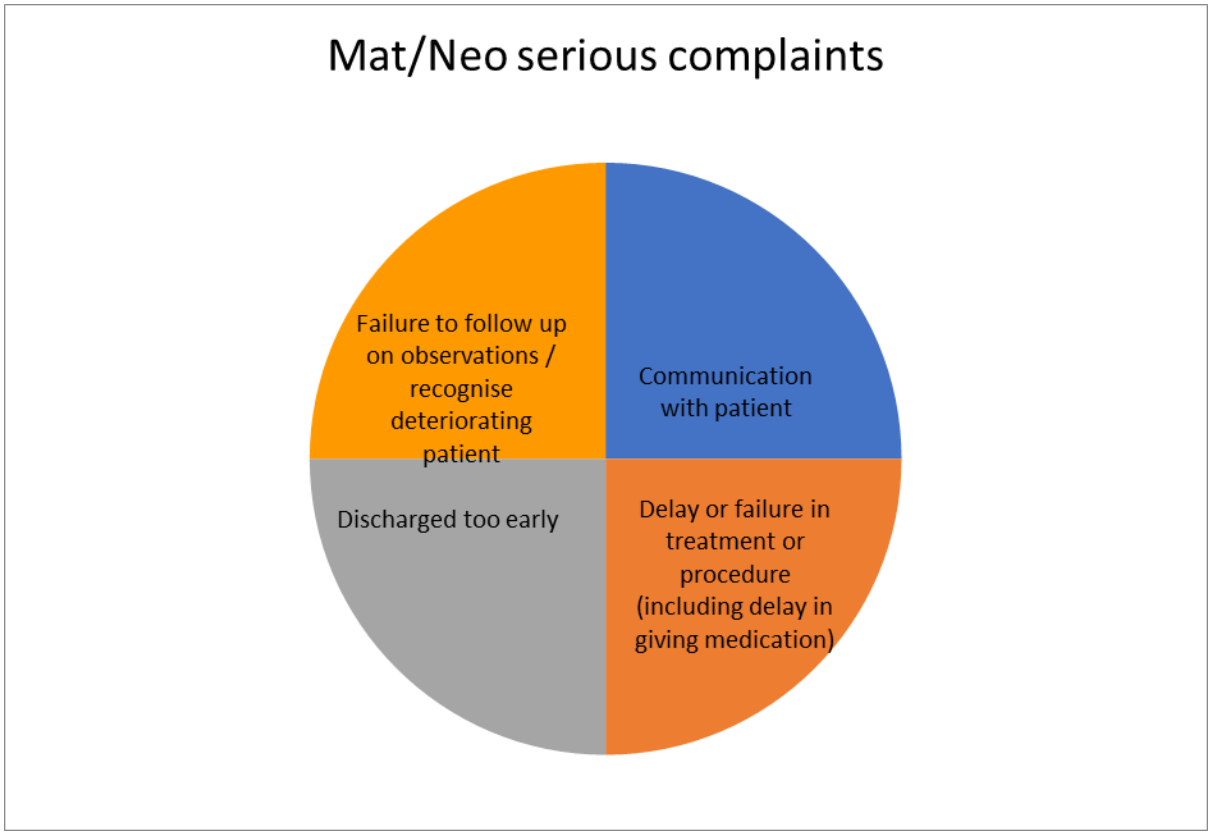


The complaints team triage complaints as either standard or serious dependent on the complexity of individual complaints. Standard complaint response time 35 days, serious complaints 65 days. There were 4 serious complaints for the maternity service during Q2.

Table: Detail of the 4 serious complaints

Date received	Specific Location	Brief description of Patient Experience	Subject	Sub-subject	Subject notes
18/07/2022	Birth Unit	No communication re debrief for traumatic birth; notes lost; patient has a number of questions about birth - Did she have a placental abruption? Why did she have a haemorrhage? Is it safe for her to have another child naturally? ; Told not to come to hospital when bleeding; No anaesthetist available for epidural; Lack of pain relief; Epidural didn't work; immediate request t transfer to stroud; no help breast feeding	Communications	Communication with patient	No communication re debrief for traumatic birth;
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	no help breast feeding
			Admission and discharges	Discharge Arrangements (inc lack of or poor planning)	immediate request to transfer to stroud despite haemorrhage
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Epidural didn'''''''''''''''''''''''''''''''t work;
				Inadequate pain management	Lack of pain relief;
				Delay or failure in treatment or procedure (including delay in giving medication)	No anaesthetist available for epidural; Lack of pain relief; Epidural didn'''''''''''''''''''''''''''''''t work; immediate request t transfer to stroud; no help breast feeding
				Delay or failure in treatment or procedure (including delay in giving medication)	Told not to come to hospital when bleeding;
			Communications	Communication with patient	patient has a number of questions about birth - Did she have a placental abruption? Why did she have a haemorrhage?
			Trust admin/policies/ procedures including patient	Trust administration issues	Notes lost;
29/09/2022	Maternity Ward Obstetrics	Pt disch and read twice with contractions and broken waters. Lack of pain relief. Incorrect meds prescribed?	Admission and discharges	Discharged too early	Pt disch and read twice with contractions and broken waters. Lack of pain relief. Incorrect meds prescribed?
			Clinical treatment	Inadequate pain management	Lack of pain relief.
			Prescribing	Prescribing error	Incorrect meds prescribed?
			Admission and discharges	Discharged too early	Pt disch and read twice with contractions and broken waters.
15/09/2022	Maternity Ward Obstetrics	Maternity triage, delay, att of midwife, lack of treatment. Lack of Obs. Health Records incorrect . Sonography- poor comms, pt had to chase appt.	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Maternity triage delay, lack of treatment lack of Obs.
	Ultrasound dept		Communications	Communication with patient	Sonography- poor comms, pt had to chase appt.
	Maternity Ward Obstetrics		Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Maternity triage lack of treatment.
			Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Maternity triage att of midwife,
02/08/2022		C Section tear questions & concerns	Clinical treatment	Failure to follow up on observations / recognise deteriorating patient	

Primary Sub-subjects of serious complaints Q2

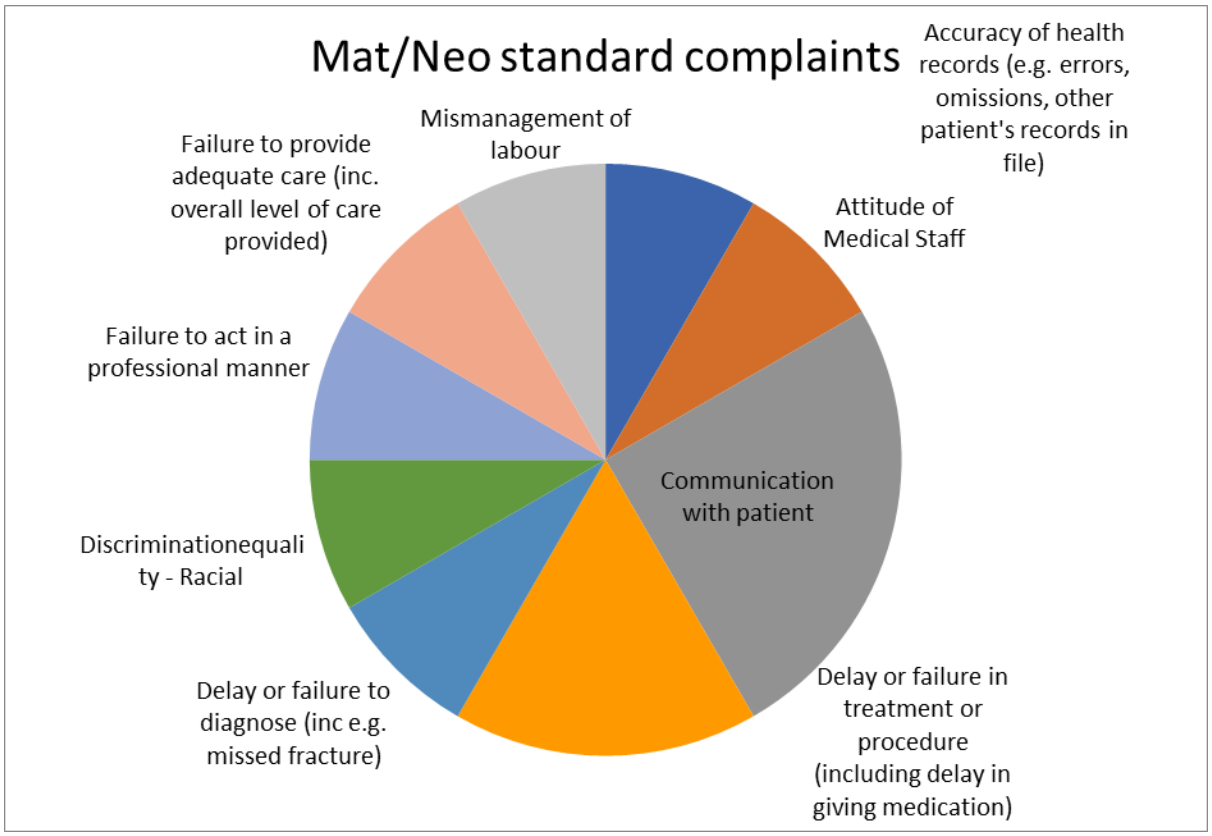


There were a further 12 complaints triaged as standard in the Maternity/Neonatal Service.

Table: Details of the 12 complaints

Date	Specialty	Specific Location	Brief description of Patient	Subject	Sub-subject	Subject notes
25/07/2022	Maternity	Maternity Theatres	Patient had retained placenta. She was taken down to have placenta removed and was informed it had been removed successfully. Unfortunately this was not the case.	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Retained placenta unsuccessfully removed - resulting in complications and distress to the patient.
28/07/2022	Maternity	Maternity Ward Obstetrics	Oversight of RPOC resulting in having to have surgery four weeks after birth.	Clinical treatment	Delay or failure to diagnose (inc e.g. missed fracture)	RPOC oversight.
16/08/2022	Maternity		poor communication by midwife at home; Poor care by doctor. Glucose administered to baby without consent. Issues re heel prick. Lack of communication re baby's care	Communications	Communication with patient	poor communication by midwife at home; Poor care by doctor. Glucose administered to baby without consent. Issues re heel prick. Lack of communication re baby's care
	Neonatology					Glucose administered to baby without consent. Issues re heel prick. Lack of communication re baby's care
05/09/2022	Maternity	Outpatients	Delay in comms from midwife, poor treatment, attitude of midwife. Diag by sonographer, att of sonographer. GP issues	Communications	Communication with patient	Delay in comms from midwife
	Radiology	X-ray		Communications	Communication with patient	Diag by sonographer
	Maternity	Outpatients		Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Attitude of midwife.
				Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Poor treatment
	Radiology	Outpatients		Values and Behaviours (Staff)	Attitude of Medical Staff	Att of sonographer.
25/09/2022	Maternity	Newborn & Infant Screening	Inappropriate behaviour of midwife support worker	Values and Behaviours (Staff)	Failure to act in a professional manner	Inappropriate behaviour of Midwife support worker
05/09/2022	Maternity		Patient went into premature labour and baby died feels that it wouldn't have happened if earlier action had been taken	Clinical treatment	Mismanagement of labour	Patient went into premature labour and baby died feels that it wouldn't have happened if earlier action had been taken
						Patient rang triage and was told to ring back if pain got any worse and take paracetamol eventually was taken to hospital. Patient feels the period of waiting had an effect on the outcome.
19/08/2022	Maternity	Maternity Ward Obstetrics	Poor after care - poor attitude of nurse on ward	Patient Care (Nursing)	Failure to provide adequate care (inc. overall level of care provided)	Failure to provide adequate care
					Call Bell - failure to respond	failure to respond to call bell.
					Food and Hydration - Failure to monitor / provide food during period of admission	Poor care in regards to food and hydration
				Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Poor attitude of midwife
31/08/2022	Maternity		1 Undiagnosed breech baby, likely breech entire pregnancy resulting in dangerous late stage c-section 2. Not screened for jaundice until 15 days post birth despite risk factors associated, and visibly jaundice. Bilirubin discovered to be high. 3. Missed severe tongue tie despite poor weight gain, breastfeeding never assessed, never observed 4. Lack of compassion and poor use of language used by the community midwife postnatally, contributing to decline in my mental health. Example "shame a few more pushes and you didn't get him out"	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	1 Undiagnosed breech baby, likely breech entire pregnancy resulting in dangerous late stage c-section
					Delay or failure in treatment or procedure (including delay in giving medication)	2. Not screened for jaundice until 15 days post birth despite risk factors associated, and visibly jaundice. Bilirubin discovered to be high.
					Delay or failure in treatment or procedure (including delay in giving medication)	1 Undiagnosed breech baby, likely breech entire pregnancy resulting in dangerous late stage c-section
				Communications	Communication with patient	4. Lack of compassion and poor use of language used by the community midwife postnatally, contributing to decline in my mental health. Example "shame a few more pushes and you didn't get him out"
16/08/2022	Maternity	Outpatients	Poor attitude of consultant	Values and Behaviours (Staff)	Attitude of Medical Staff	Poor attitude of Consultant
11/07/2022	Maternity	Maternity Ward Obstetrics	Community - lack of adequate care from community midwife. Lack of communication from community midwife. Use of trainee to carry out important tasks. Triage - conflicting advice from triage staff. Comments by midwife. Lack of consultant referral. Consultant uncaring. Pre-op - Communication with pre-op midwife. Postnatal - staff did not respond to buzzer. Community - lack of assistance re breast feeding.	Communications	Communication with patient	Community - Lack of adequate communication from community midwife.
				Clinical treatment	Incorrect procedure	Community - lack of assistance re breast feeding.
				Communications	Communication with patient	Pre-op - Communication with pre-op midwife. Postnatal - staff did not respond to buzzer. Community - lack of assistance re breast feeding.
					Communication with patient	Consultant uncaring.
				Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Lack of consultant referral.
				Communications	Communication with patient	Triage - conflicting advice from triage staff and Comments by midwife.
				Clinical treatment	Incorrect treatment	Use of trainee to carry out important tasks.
01/09/2022	Maternity	Maternity Ward Obstetrics	Patient requires post birth debrief bit notes are missing	Trust admin/policies/ procedures including patient record management	Accuracy of health records (e.g. errors, omissions, other patient's records in file)	Patient requires post birth debrief bit notes are missing
27/07/2022	Maternity	Maternity Ward Obstetrics	Question of standard of care/professionalism	Privacy, Dignity and Wellbeing	Discriminationequality - Racial	Patient claims unconscious racial bias due to care received.
					Lack of privacy / dignity	Photographs taken without patients consent on Consultants and midwifes personal mobile phones.
				Patient Care (Nursing)	Cannula management	Cannula management
					Failure to provide adequate care (inc. overall level of care provided)	Patient unhappy with overall care received by midwife,

Sub-subject of Standard complaints Q2



Friends and family test

Friends & Family has recently been expanded to include further questions relating to Continutiy of Carer and also to endure feedback is attribital to the actual place of birth and not amalgamated into feedback on the postnatal ward these questions have been seperated. An improvement in scores was seen this quarter with July & September achieving above 90% positive feedback across the service.

Improvement Plan

The Maternity Voices Partnership (MVP) have a plan for improvement and our patient action plan will co-designed with the MVP. Attendance at that meeting has been reduced due to staffing shortages.

Safety action 8 - evidence of local training plan is in place to ensure that all six core modules of the Core Compentency Framework

The service has fallen below target levels with mandatory training. Mandatory training including PROMPT and Midwives mandatory study days were cancelled in January. Midwives have been asked to undertake mandatory training as bank work during this training year where they are able to.

The updated Matrnity Incentive Scheme version 5 published in October 2022 has reduced the timeframe to demonstrate compliance from August 2021 to December 2022 to any 12 month period between August 21 and 5th December 2022. This means that staff trained during Sept and October 2021 are now no longer compliant for this year.

Table: current PROMPT compliance – 2021-22 for training year commencing **November** 21

% Compliance for different elements PROMPT		
		Number needed to attend training to be compliant
Midwives (incl. bank)	81%	28
Consultant Obstetricians	92%	
Junior Obstetricians	76%	3
Anaesthetists	59%	8
MCA/MSW	79%	9

Improvement plan

An additional study day is being added for fetal monitoring in November. All staff who have not attended and their line manager have been contacted to remind them to attend booked training in November. An educational training review has been commissioned to review the current requirements to make sure that we are making best use of opportunities. The plan is to have increased compliance to 90% by 23rd November 2022.

Safety action 9 - processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues

Maternity Safety Champions (MSCs) work at every level – trust, regional and national – and across regional, organisational and service boundaries. Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions.

The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. Maternity Service Champions build the maternity safety movement in our service locally.

The Trust Maternity Safety Champions have been meeting on a monthly basis.

Improvement action

- A Safety intelligence pathway from ward to Board needs to be refreshed to include the **Perinatal Quality Surveillance** (PQS) Model.
- The Board level maternity service champion will present the PQS Dashboard and Report to Board quarterly.
- Our MCoC action plan is to be reviewed by MSCs.
- The MSCs are to have oversight of the Neonatal Critical Care Review Recommendations.
- The MSCs should support the safety culture improvement plan.

Safety Action 10 - reported 100% qualifying cases to Health Care Safety Investigation Branch (HSIB) and to the NHS Resolution's Early Notification schemes

Serious incidents

The purpose of serious incident reporting and learning is to demonstrate good governance and safety for the most serious incidents. The aim of this Q2 update is to provide assurance to the Board that the maternity service is compliant with the contractual standards for

investigations, that immediate learning happens (72 hour reports) and that recommendations made are developed in action plans which are then implemented. Where the incident meets the HSIB criteria these are referred to them to investigate.

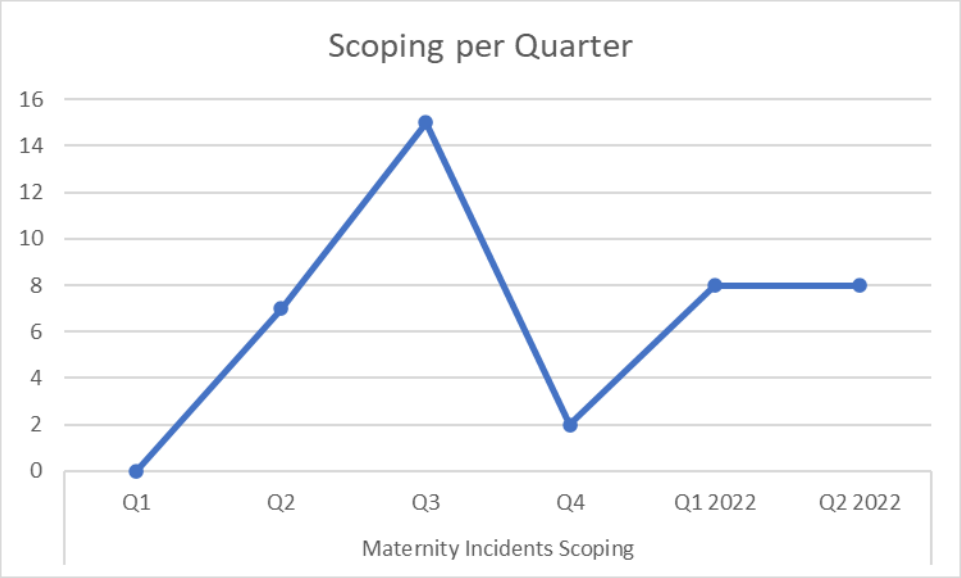
Governance

At the service level, the Maternity Clinical Governance Meeting has oversight of the serious incident management process. The Division reports through to the Trust level the Safety and Experience Review Group as they have detailed oversight escalating any concerns to the Quality Delivery Group. All incidents that have been scoped within maternity are presented to the weekly SI panel.

Serious incident reporting

Serious incidents must be declared as soon as possible and in order to do this incident that have been identified as serious in nature undergo a scoping exercise. In Q2 there were a total of 8 incidents scoped, 6 of which were HSIB referrals including 1 referred by North Bristol Trust so not a GHNHSFT referral or SI. 1 case was rejected by HSIB therefore there were 4 SI's. 1 further case is awaiting further information for the SI panel to decide on status. 1 case was graded as no harm.

Table: Total number of incidents scoped per quarter



The Trust is required to report all qualifying cases to HSIB and of the 8 incidents scoped 5 were reported to HSIB, 1 of which was rejected

Table: Details of incidents scoped in Q2

Incident Number	Speciality	Incident Summary	Immediate actions including level of harm/referral to HSIB
W1849948	Maternity	T+12 IOL but spontaneously went into labour with SRM and contractions. IUD confirmed on admission- clinical picture of placental abruption	HSIB/SI Immediate Safety Act's: On attending clinical areas for induction of labour, women should be asked: 1. Are fetal movements being felt as normal 2. if they have any pv loss and if so, the colour, and 3. Following abdominal palpation, FHR should be auscultated
W187047	Maternity	31+1 NND at 1 hour old	No Harm Immediate Safety Act's: Learning – 1. Category 1 sections to go theatre straightaway. Actions – 1. Discuss with SB to find out whose responsibility it is to call in the on-call paediatrician. (JF) 2. Check to see if the thrombophilia screen was completed. (EC) 3. Contact Warwick Hospital to find out what time the patient originally rang them and what advise was given to the woman. (LB) 4. Discussion to be held with the team to find out why there was a 16-minute delay in going to theatre, what was happening during this time? (LB)
W188975	Maternity	Approx. 8/40 maternal death in community, unbooked. COD – PE	HSIB/SI Immediate Safety Act's: None identified
W188936	Maternity	GDM 37+3 Shoulder Dystocia #Humerus, seizures, Apgars 0,1,1 transferred to Southmead for cooling.	Rejected HSIB Immediate Safety Act's: None identified
W189499 / W189493	Maternity	38+6 Called 999 bleeding. SWAST though clinical picture was not as per 999 call. Asked for woman to make her own way in but no transport. BBA outside unit, poor apgars and gases, Transferred for cooling.	HSIB/SI Immediate Safety Act's: 1. Reminder to be sent out regarding Aspirin being recommended and commenced for all women that meet criteria. Community Matron emailed by risk team on 14/09/22 to ask

			Community Team leaders to circulate information to their community teams. A new updated SGA proforma has already been through the GOGG process, and will be re launched to staff once the new forms have been received from colour connect- these will be placed into all booking packs. 2. Decision on 15/09/22- Communication to be circulated regarding appropriate place to commence Neonatal resuscitation in the event of a BBA and importance of emergency call stating clearly where the team attending the emergency are required to attend.
W189719	Paediatric	Ingestion of x2 items whilst under 4:1 care- required endoscopy at Bristol.	?MH <u>Immediate Safety Act's:</u> None identified
W189992	Maternity	CAT 1 LSCS for fetal bradycardia- placental abruption. PPH 2250mls, Transferred to ITU haemodynamically unstable.	?SI <u>Immediate Safety Act's:</u> Action: 1. Update the flow chart/action card for policy Learning: 1. Communication to be sent to the community team regarding a patient has a + protein then they should be sending a UPCR. 2. If a patient has PET, IOL should be booked for 37/40. Individual, departmental and prompt learning.
W190314	Maternity	18+2 Primip, collapsed at home - cardiac arrest - received Heparin then transferred to Southmead. RIP ? PE	HSIB (Bristol) <u>Immediate Safety Act's:</u> 1. Communication to be sent to the community team to revisit the antenatal VTE risk assessment for patients that are covid positive as this is an additional risk factor. GWH pathway to be reviewed. 2. AL to check the virtual covid ward and how it works. 3. Communication to be sent to GP surgeries in regards to covid positive pregnant patients. 4. JF to check all outstanding

			appointments have been cancelled. 5. LB to follow up Southmead for post mortem. 6. REJ to allocate a member of staff to update the covid SOP to reflect clinical guideline.
W191600	Maternity	IOL @ 38/40 GDM diet controlled, EFW 7th centile. 1 x propess, 4 x prostin, awaiting ARM, stillbirth on Mat Ward 38+4.	HSIB/SI <u>Immediate Safety Act's:</u> 1. Reminder to all clinicians has been circulated, regarding the IOL policy: A conversation to be had with woman after either the propess or 2 prostins: *Failed induction – defined as labour not starting after one cycle of treatment. An Obstetrician will discuss this with the woman and reassess the pregnancy and fetal wellbeing. Take the woman's wishes into consideration. Options include: • A further attempt to induce labour, the timing dependant on the clinical situation and the woman's wishes. This might include a rest day • Following two cycles of vaginal PGE2, no further PGE2 should be given without discussion with a consultant obstetrician* 2. *LS/CE have already discussed and are exploring the option of utilising an electronic IOL list which will contain real-time up to date information* 3. *Notable practice: NHS England who were in attendance at GRH at the time of incidence, commented on the very good levels of support offered to the those involved in this incident.*

<u>HSIB Cases</u>

The HSIB Maternity investigation programme is part of a national plan to make maternity care safer. HSIB investigate incidents that meet the HSIB and MBRRACE-UK criteria. HSIB investigations replace internal serious incident investigations. HSIB involve the Trust and share the investigation reports once they are completed. The Trust continue to investigate maternity events that fall outside the HSIB specified criteria.

<u>Governance</u>

The maternity service remains responsible for Duty of Candour, 72-hour reports and reporting via the Strategic Executive Information System (STEIS). HSIB provide 2 weekly investigation progress reports to the Trust and meet with the Trust on a quarterly basis to share learning, themes and trends.

Table: Total HSIB investigation activity since April 2018

Cases to date	
Total referrals	54
Referrals / cases rejected	28
Total investigations to date	26
Total investigations completed	21
Current active cases	5
Exception reporting	2 exceptions on case (MI-011049)

Graph: Maternity investigation categories

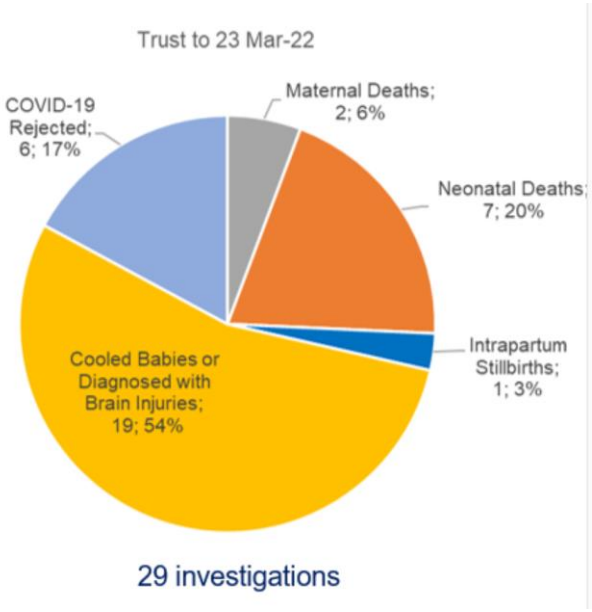


Table: HSIB activity in Q1

HSIB case number	Qualifying criteria	Investigation progress	Improvement
MI-006101	HIE/Cooling 37+0 Contractions/Abdo Pain, Pathological CTG, Cat 1 EMCS, Uterine Rupture. (January 22)	Draft report received (4 recommendations made) .	**Action plan presented and agreed at SERG**
MI-008110	HIE/Cooling T+14 undx breech, EMCS	Draft report shared and factual accuracy returned to HSIB. Awaiting final report	
MI-11049	Intrapartum Stillbirth	Staff interviews completed. Draft report writing commenced	
MI-013652	Maternal Death	Family interview arranged	

HSIB case number	Qualifying criteria	Investigation progress	Improvement
MI-014046	HIE/Cooling	Documents uploaded to HSIB	

Table: Details of family involvement in HSIB investigations

Date range	Families not agreeing to contact from HSIB	Families contacted by HSIB but not agreeing to participate	Families engaging with HSIB
Q1 20/21	7.2%	8.6%	84.2%
Q2 20/21	7.3%	10.5%	82.2%
Q3 20/21	7.9%	7.1%	85.1%
Q4 20/21	7.4%	3.5%	89.1%
Q1 21/22	6.2%	6.2%	87.7%
Q2 21/22	6.7%	6.7%	86.6%
Q3 21/22	7.6%	8.5%	83.9%

NHS Resolution Early Notification Scheme

The scheme aims to provide a more rapid and caring response to families whose babies may have suffered harm. On completion of the HSIB safety investigation, where a case has progressed following referral for potential severe brain injury, a copy of the final report is shared with NHSR for them to review and decide whether there is any evidence that could potentially result in compensation.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**06c**
Date	10 November 2022		
Title	Maternity Safer Staffing Report		
Author /Sponsoring Director/Presenter	Lisa Stephens, Head of Midwifery Suzie Cro, Deputy Director of Quality Matt Holdaway, Chief Nurse and Director of Quality		

Purpose of Report			Tick all that apply ✓
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	✓
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report

Purpose

The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of safe staffing levels. This report covers the period Jan – June 2022.

Key issues to note

The Covid-19 pandemic has increased staff related absences and has provided further complexity to the Maternity Service provision. CQC carried out an unannounced focused inspection rated the service as inadequate and one of the issues identified was that there was not always having enough staff to care for women and keep them safe and a section 29A warning notice was issued (May 2022).

Obstetric medical workforce

The obstetric consultant team and maternity senior management team have acknowledged and are committed to incorporating the principles outlined in the RCOG (June 2021) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the maternity service. Audits monitoring compliance with consultant attendance have commenced. In the most recent audit the consultant was present in 83.3% of cases (90.9% of cases where called) and Consultant was in another theatre for the other case they were called. A Monthly audit is now planned following daily assessment completed by Band 7 Co-Ordinator / obstetric team. Action plan for non -compliance reported to Maternity Safety Group presented by Speciality Director (SD).

Anaesthetic medical workforce

The Trust meets the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) as a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.

Neonatal medical workforce

The Trust meets the BAPM national standards for junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (2022)).

Neonatal nursing workforce

The neonatal unit meets the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed on the 14/03/2022. The neonatal unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines.

Midwifery workforce

Midwifery workforce review

Currently a **BirthRate plus** (BR+) full review of midwifery staffing has been completed and the report is due in the autumn 2022. If the funded establishment is not compliant with the BR+ report, the Head of Midwifery, with the Divisional Director of Operations, will complete an action plan and this will be presented to the Trust Board.

Risk Register entry

Midwifery staffing is on the **Trust risk register** with a score of 15 for safety.

Planned to actual staffing ratios

- The **midwife to birth ratio** has fluctuated during the 6-month period. The average was: 1:29 (best practice 1:28). Compliance with the accepted ratio of 1:28 was not achieved during January, March and July which was associated with high levels of midwifery sickness. The midwife to birth ratio continues to be monitored and reported to the Chief Nurse monthly via the Maternity Delivery Group.
- The ratio of midwife to mother **1:1 care in labour** is monitored and reported monthly. Data Is acquired from Trakcare and discrepancies are analysed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri. The average of: 1:1 Care in labour compliance is 97% based on Trakcare data which provides a service wide overview. An action plan has been provided at appendix 1).
- There is a daily touchpoint by Matrons/**Flow Midwife** and Head of Midwifery to review and plan forecasted staffing and activity. Mitigation around red flags associated with staffing are addressed by this team or by the Band 7 CDS coordinator and Senior Midwife Manager on Call out of hours.
- Typical escalation and mitigation include:
    - Redeploying staff
    - Utilisation of on-call staff
    - Reviewing and temporarily pausing elective activity
    - Closure of units or whole unit closure
- The percentage of **specialist midwives** employed is 11.82 % of the total midwifery workforce establishment which are not included in the direct care numbers (meets the standard which is advised at 8-10%).

Midwifery Continuity of care

Following the NHSE recommendation on staffing issued on the 1st of April, a commitment was made at Directors Operational Group (DOAG) in July 2022 to ensure the correct midwifery workforce in place before moving forward with further Continuity roll out. Three teams were launched in April 2021 and due to recruitment and retention issues this has now reduced to currently two teams providing care in this way.

Red Flags are incidences of possible concern with staffing

- Red flags as outlined by NICE (2015) safer staffing are captured via BR+. Red flags are monitored daily and high incidences reported at the monthly MDG. The most frequent staffing Red Flag was associated with delays in Induction of labour. There was a range of between 4 and 17 episodes a month. CQC flagged this as an issue for the service in the S29a warning notice and now there is a Quality Improvement (QI) project underway to support learning and improvement.
- The Midwifery Coordinator has supernumerary status and there were no times when this status was not

maintained and therefore 100% compliance was achieved.

Conclusion

Midwifery Staffing remains on the Trust Risk Register. The evidence described in this report provides assurance that there are effective workforce planning tools being used currently to review current establishments. This report describes the urgent action being taken to tackle the staff shortages and the increased pressures this has on staff, which have been exacerbated by the Covid-19 pandemic.

Recommendation

The Board is asked to note the contents of the report.

Enclosures

- Maternity Safer Staffing Report
- Appendix 1 – action plan for 1:1 care in labour

BOARD 10 November 2022

MATERNITY STAFFING REPORT

1. Purpose of Report

1.1. The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of maternity safe staffing levels.
1.2. This report covers the period January to June 2022.
1.3. Our focus was to ensure women, babies and their families receive the maternity care they need, including care in all:

- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units)
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services).

This should be regardless of the time of the day or the day of the week. The service should be able to deal with fluctuations in demand (such as planned and unplanned admissions and transfers, and daily variations in requirements for intrapartum care).

2. Executive Summary

2.1. An **unannounced focused inspection by the CQC** to Maternity Services in April 2022 has led to an overall **inadequate rating** of the service in July 2022. The rating was influenced by their findings that the service did not always have enough staff to care for women and keep them safe.
2.2. Midwifery Staffing has remained critical with vacancies in the region of 10 - 20 whole time equivalents (WTE) which has been exacerbated by increased sickness rates and increased maternity leave rates. Midwifery staffing remains on the **Trust Risk Register** with a score of 15 for safety. Controls are in place to mitigate the risk and a staffing improvement plan is being enacted with oversight of the plan at the Executive led Maternity Delivery Group (MDG) supported by the Deputy Director of Quality.
2.3. Currently a **BirthRate plus** (BR+) full review of midwifery staffing is being undertaken and the report is due in the autumn 2022.
2.4. An extensive midwifery staffing plan for 2022 was developed and is progressing with **notable achievements** of:

- Recruitment to a newly formed Recruitment and Retention Team including: Recruitment and Retention midwives, International Recruitment midwife, International Recruitment Midwife, Dedicated Professional Midwifery Advocate (PMA) for new starters and an advert currently out for a Recruitment and Retention project manager.
- Organisational Development Lead for Midwives in post
- Commencement of Midwifery Wellbeing Evaluation which is led by a clinical

psychologist. We have been approached to lead this as a national pilot.

- The maternity service is required to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. Below is a summary table of our progress against the Maternity Incentive Scheme Standards 4 and 5.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Table1: Summary of Maternity Workforce position in relation to Maternity Incentive Scheme standards

Professional group	Current position	RAG rating
Midwifery Workforce	**Midwifery workforce** <u>Midwifery workforce review</u> – Currently a **BirthRate plus** (BR+) full review of midwifery staffing has been completed and the report is due in the autumn 2022. If the funded establishment is not compliant with the BR+ report, the Head of Midwifery, with the Divisional Director of Operations, will complete an action plan and this will be presented to the Trust Board. <u>Risk Register entry</u> – Midwifery staffing is on the **Trust risk register** with a score of 15 for safety. <u>Planned to actual staffing ratios</u> – The **midwife to birth ratio** has fluctuated during the 6-month period. The average was: 1:29 (best practice 1:28). Compliance with the accepted ratio of 1:28 was not achieved during January, March and July which was associated with high levels of midwifery sickness. The midwife to birth ratio continues to be monitored and reported to the Chief Nurse monthly via the Maternity Delivery Group.	Reason for amber rating- Birth rate plus report awaited.

Professional group	Current position	RAG rating
	– The ratio of midwife to mother **1:1 care in labour** is monitored and reported monthly. Data Is acquired from Trakcare and discrepancies are analysed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri. The average of: 1:1 Care in labour compliance is 97% based on Trakcare data which provides a service wide overview. – There is a daily touchpoint by Matrons/**Flow Midwife** and Head of Midwifery to review and plan forecasted staffing and activity. Mitigation around red flags associated with staffing are addressed by this team or by the Band 7 CDS coordinator and Senior Midwife Manager on Call out of hours. – Typical escalation and mitigation include: o Redeploying staff o Utilisation of on-call staff o Reviewing and temporarily pausing elective activity o Closure of units or whole unit closure – The percentage of **specialist midwives** employed is 11.82 % of the total midwifery workforce establishment which are not included in the direct care numbers (meets the standard which is advised at 8-10%). <u>Midwifery Continuity of care</u> – Following the NHSE recommendation on staffing issued on the 1st of April, a commitment was made at Directors Operational Group (DOAG) in July 2022 to ensure the correct midwifery workforce in place before moving forward with further Continuity roll out. Three teams were launched in April 2021 and due to recruitment and retention issues this has now reduced to	

Professional group	Current position	RAG rating
	currently two teams providing care in this way. <u>Red Flags are incidences of possible concern with staffing</u> – Red flags as outlined by NICE (2015) Safer Midwifery Staffing are captured via BR+. Red flags are monitored daily and high incidences reported at the monthly MDG. – The most frequent staffing Red Flag was associated with delays in Induction of labour. There was a range of between 4 and 17 episodes a month. CQC flagged this as an issue for the service in the S29a warning notice and now there is a Quality Improvement (QI) project underway to support learning and improvement. – The Midwifery Coordinator has supernumerary status and there were no times when this status was not maintained and therefore 100% compliance was achieved.	
Obstetric Medical Workforce	The maternity service acknowledges and commits to incorporating the principle outlined in the RCOG document "Roles and Responsibilities of Consultants" into the service. A Gap analysis is in progress and has been discussed at the consultant meetings. The consultants are fully engaged with the report and are prioritising the improvement plan. The work so far has been presented at the Patient Safety Meeting. Priorities will be confirmed by the end of December. There are 13 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (provide 77.5 hours/week direct cover), and then on call cover overnight. Audits monitoring compliance with consultant attendance have commenced. In the most recent audit the consultant was present in 83.3% of cases (90.9% of cases where called) and Consultant was in another theatre for the other case they were	Standard met

Professional group	Current position	RAG rating
	called. A Monthly audit is now planned following daily assessment completed by Band 7 Co-Ordinator / obstetric team. Action plan for non - compliance reported to Maternity Safety Group presented by Speciality Director (SD).	
Anaesthetic Medical Workforce	To meet the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.	Standard met
Neonatal Medical workforce	The Neonatal SD has confirmed that the Trust meets the British Association of Perinatal Medicine (BAPM) national standards in full for junior medical neonatal staffing, exceeding required BAPM standards (this data was confirmed 12 months ago).	Standard met
Neonatal nurse workforce	The neonatal unit meets the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed on the 14/03/2022. The neonatal unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines.	Standard met

3. Background

3.1. The National Quality Board (NQB) standards for nursing and midwifery (2018) provide the guidelines for NHS providers and this paper describes the Trust's approach to meeting those expectations/ standards. the NQB standards demand a triangulated approach to staffing decisions with 3 expectations around Right Staff, Right Skills, Right Place and Time

3.2. The publication of a range of highly critical reports surrounding maternity units including the Ockendon Final Report (2022), Report of the Morecambe Bay investigation (2015), Cwm Taf Morgannwg (2017) and Shrewsbury and Telford (2020) have contributed to the high profile afforded to maternity safety and quality. Findings from Nottingham and East Kent will add to the picture on maternity with the second Kirkup report delayed until October 2022.

3.3. NICE guidance - Safe midwifery staffing for maternity settings published in 2015 identified recommendations surrounding organisational requirements, setting the

midwifery establishment, assessing the difference in number and skill mix of midwives, and monitoring and evaluating midwifery staffing requirements.

3.4. Year four of the Maternity Incentive Scheme (MIS) (NHSR, 2021) asks Trusts to continue to apply the principles of the 10 safety actions and given that the aim of MIS is to support the delivery of safer maternity care, workforce planning and review are within standard 4 and 5 of the scheme. This report has been written to meet these standards so that we can demonstrate we have an effective system of clinical workforce planning to the specified standards and have action plans in place for any gaps/issues identified.

3.5. Midwifery Staffing expectations include the following:

- Deliver all pre-conception, antenatal, intrapartum and postnatal care needed by women and babies
- Provide midwifery staff to cover all the midwifery roles needed for each maternity service, including co-ordination and oversight of each service
- Allow for locally agreed midwifery skill mixes (for example, specialist and consultant midwives and practice development midwives)
- Provide a woman in established labour with supportive one-to-one care
- Provide midwife to birth ratios as per Birthrate plus
- Allow for planned and unplanned leave
- Time for professional midwifery advocate role
- Ability to deal with fluctuations in demand
- Ensure professional support and leadership for clinical teams (Midwifery, Obstetric Neonatal, anesthetic) in and out of hours

OBSTETRIC MEDICAL WORKFORCE

4. Obstetric medical workforce

4.1. The medical Obstetric team currently comprises: -

- 13 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (77.5 hours/week), and then on call overnight.
- 24-hour Registrar presence for obstetrics, supported by a registrar for gynaecology, with 12.5-hour shifts
- 24 hour SHO presence – 0830-1700 for obstetrics, 1700-0830 and weekends for both obstetrics and gynaecology
- A Registrar for the elective caesarean section list, 5 days a week, from 0830-1700; supported by the Gynaecology consultant
- 13 weekly Consultant run antenatal clinics across the county, including specialist clinics for:
    - Maternal medicine
    - Perinatal mental health
    - Substance misuse and blood borne viruses
    - Teenage pregnancies

    - High BMI
    - Preterm birth prevention (about to be started)
    - Diabetic medicine
- There are 6 consultant fetal medicine sessions per week, across both sites
- The number of consultant antenatal clinics has recently increased with plans to introduce a further additional weekly clinic.
- An Obstetrician, Matron and Head of Midwifery facilitate a weekly MDT 'Birth options' meeting

4.2. The obstetric consultant team and maternity senior management team have acknowledged and committed to incorporating the principles outlined in the RCOG (June 2021) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the maternity service.

Picture: Roles and responsibilities of an O&G Consultant

4.3. The maternity service will monitor compliance of consultant attendance for the clinical situations listed in this document for when a consultant is required to attend in person.

Picture: Situations when the on-call Consultant MUST attend.

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

4.4. Episodes where attendance has not been possible will be reviewed at the unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

4.5. Audits related to consultant attendance have commenced. In the most recent audit the consultant was present in 83.3% of cases (90.9% of cases where called) and was in another theatre for the other case they were called. The audits will be reviewed by the Board Maternity Safety Champions.

OBSTETRIC ANAESTHETIC MEDICAL WORKFORCE

5. Obstetric anaesthetic medical cover

5.1. The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The Royal College of Anaesthetists published updated guidelines on Staffing requirements in February 2022, Guidelines for the Provision of Anaesthesia Services for an Obstetric Population.

5.2. The duty anaesthetist's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The duty anaesthetist will be a Consultant, an anaesthetic trainee or a staff grade, associate specialist and specialty (SAS) doctor. Gloucester Hospitals Maternity service is fully compliant with this recommendation.

5.3. There is a duty anaesthetist immediately available for the obstetric unit 24/7. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The role should not include undertaking elective work during the duty period. GHT Maternity Service is fully compliant with this recommendation (Appendix 2 Obstetric Anaesthetic Rota GHNHSFT)

5.4. In units offering a 24-hour regional anaesthesia service, the duty anaesthetist should be resident on the hospital site where the regional anaesthesia is provided (not at a nearby hospital). Service is fully compliant.

5.5. As a basic minimum for any obstetric unit, a consultant or other autonomously practicing anaesthetist should be allocated to ensure senior cover for the full daytime working week; that is, ensuring that Monday to Friday morning and afternoon sessions are staffed. Service is fully compliant.

5.6. The national recommendation is that busier obstetric units should consider having two duty anaesthetists available 24/7, in addition to the supervising consultant. GHT maintains a 95% compliance with two duty anaesthetists during the hours of 0800-1800 Monday to Friday.

5.7. Funding is not at present available for a second duty anaesthetist out of hours or at weekends. Mitigation for the risk of 2nd anaesthetist in these cases is that the senior anaesthetic trainee on call, who also covers anaesthetic services in other departments (ED, DCC, Theatres), should be called.

5.8. A cross divisional group are considering solutions to provide a second theatre team to maternity out of hours and an paper has been prepared and shared for further discussion. This relates to Risk Register entry WC3583 which currently scores 9 for safety. Combined with two other Risk Register entries (WC3481Obs and S3621TH) Maternity theatre, it is felt that this would result in a combined risk score of 15

5.9. The duty anaesthetist has a clear line of communication to the supervising consultant at all times

5.10. The anaesthetist who is on duty for delivery suite attends the MDT handover and ward round alongside the Obstetric Consultant, Obstetric Registrar. Evidence of compliance for this requirement is kept on delivery suite. Should the duty anaesthetist be attending a woman (in theatre or delivery room) when the round takes place the Obstetric Registrar will hand over any relevant information as soon as the anaesthetist is available to facilitate a share mental model of the existing workload/potential patients. There is an ongoing audit of anaesthetic presence on MDT handovers and ward rounds, indicating excellent compliance at the 8:30am handover and ward round, but we are currently failing the standards at the evening 8:30pm handover and ward round due to the duty anaesthetist being clinically engaged during that time (theatre work or siting an epidural).

5.11. Additional consultant programmed activities are allocated for:

- elective caesarean deliveries – service fully compliant
- antenatal anaesthetic clinics – service fully compliant

5.12. Consultant support is available at all times with a response time of not more than half an hour to attend the delivery suite, and maternity operating theatre. The supervising consultant should not therefore be responsible for two or more geographically separate obstetric units. GHT Maternity Service is fully compliant with this recommendation

5.13. In busy units, increased levels of consultant or other autonomously practicing anaesthetist cover may be necessary and should reflect the level of consultant obstetrician staffing in the unit. This may involve extending the working day to include senior presence into the evening session and/or increasing numbers of autonomously practicing anaesthetists. A cross divisional MDT working group have completed an Obstetric SBAR paper to support extension of maternity theatre hours from 4pm to 6pm Monday to Friday.

5.14. In addition, there is a cross divisional MDT subgroup that are looking at the feasibility of an out of hours maternity theatre team

5.15. **In summary**, to meet the NHSR MIS Standards (Oct 2022) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. There is a clear guideline on when escalation to the on-call consultant should happen. Where there is a need for a second obstetric anaesthetist (between 18:00 and 08:00), the senior resident on call registrar will immediately attend. If the senior resident on call registrar is engaged in care with other non-obstetric patient, he/she will attend as soon as they are able to delegate care of their non-obstetric patients. (ACSA standard 1.7.2.1).

NEONATAL MEDICAL WORKFORCE

6. Neonatal Medical Workforce

6.1. There are 6 Neonatal Consultants full time with split rota allowing specialist cover for neonatal unit 24 hours a day, 7 days a week.

6.2. Daily ward rounds. Resident 09.00-17.00 weekdays and 09.00-14.00 weekends

- 24 hr tier 2 resident cover
- 24 hr tier 1 resident cover, with additional 2 tier 1s 09.00-17.00

- The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (Oct 2022)).

NEONATAL NURSING WORKFORCE

7. Neonatal Nursing Workforce

7.1. The Neonatal Unit is part of the Paediatric Service Line and is part of the Women and Children's Division.

7.2. The Clinical Lead and Matron; together with the Senior Sisters and other Neonatal Consultants comprise the Neonatal Unit Management Team and will devise the strategic plan for the unit. The Team will meet regularly to discuss on-going issues and will participate in Neonatal Risk and other meetings.

7.3. The unit is funded for 11 WTE neonatal nurses (inclusive of Nursery nurses registered nurses without the Qualification in specialty) on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

7.4. Agency and bank are utilised if required and admin/teaching days are withdrawn depending on clinical needs of the unit.

7.5. Staffing was reviewed as part of the SW Neonatal Network and Gloucester was awarded £115,092 to enhance nursing care (this funding has yet to be allocated to posts).

7.6. Year to date the unit has not had its GIRFT assessment. This took place on the 24th of May 2022 and there is an associated action plan

7.7. The Unit has been challenged in relation to nurse staffing due to high numbers of maternity leave (11 members of staff) and 5 on long term sick.

7.8. We have followed our Escalation plans to support nursing which has included utilising all nursing time in to clinical shifts and advanced booking of agency nurses who are Neonatal Qualified in Specialty (QIS) trained.

7.9. The neonatal unit records all of its nursing numbers and acuity data on the electronic system Safe Care Live and this is reviewed daily by the senior nursing team to ensure the staffing is as per recommendation. Nursing skill mix is based on BAPAM guidance and recorded on Badgernet which is also reviewed by the team locally as well as the Neonatal network.

MIDWIFERY STAFFING

8. Right staff - evidence based midwifery workforce planning

8.1. Birthrate+ (BR+) is a framework for workforce planning and strategic decision-making

and has been in use in UK maternity units for a significant number of years. GHT had a formal midwifery workforce review completed by BR+ in early 2019 detailing that an uplift of midwifery staffing was required, which was funded.

8.2. Currently a BR+ review is being undertaken and the report was due in Spring 2022. There have been significant delays due to issues associated with data quality for the assessment, and the results are now anticipated in Autumn 2022. Once the results have been received an action plan will be drawn up and this will be presented to Divisional Board with any issues/concerns escalated. To meet the NHSR Maternity Incentive Scheme Safety Action 5 this report and action plan must be presented to the Trust Board when completed.

8.3. As recommended, there are currently 11.82 % of specialist midwives and midwives in managerial positions employed and this accounts for 8-10% of the establishment, which are not included in clinical numbers, as recommended by BR+ (NHSR Maternity Incentive Scheme Safety Action 5). The table below is a breakdown of the various managerial and specialist midwives total. The In-post total exceeds funded establishment as there has been significant external funding sought with fixed term posts for specialist posts arising from drivers such as Ockendon and national midwifery staffing situation.

	Band	**Funded establishment**	**WTE in post – Dec 21**	**WTE in post – July 22**
Managerial Position	8	6	6.0	6.8 (1 WTE Long term sick)
Specialist Midwives	6/7	15.71		22.63

8.4. Below is the breakdown of the midwifery clinical establishment as supported by Birthrate+ and this includes the professional judgement of the senior midwifery team.

Table 4: Funded midwifery clinical establishment July 22 *(Source: ESR)*

	Band	**Funded establishment**	**WTE in post – July 22**
Team Leaders	7	22.16	26.22
Clinical Midwives	5/6	218.25	185.46
	Total	**240.41**	**211.68**

8.5. In addition to the clinical establishment are the specialist posts and managerial positions (calculated by BR+ at approximately 8-10% of the clinical workforce). Our current figure is 11% The specialist posts and managerial posts will be reviewed as part of the next BR+ review.

8.6. Specialist midwives within the Trust have a key role in the wider public and social health. Additional funds NHSE/I funds were made available to the Trust to support meeting CNST MIS and Ockendon requirements.

8.7. The publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust on 10 December 2020 described immediate and essential actions (IEAs).To reduce variation in experience and outcomes for women and their families across England, NHS England and Improvement invested money to support the system to address all 7 IEAs consistently and to bring sustained improvement in our maternity services. The midwifery element of this funding was offered to increase the Band 5/6 midwifery workforce establishment nationally by 1200 FTE midwives in 2021/22. Locally the following additional posts are being considered.

Investment detail	BAND	WTE
Practice Development Midwife	6	1.0
Fetal Monitoring Midwife	7	0.6
Safeguarding	8a	1.0
Patient safety champions	6	0.1
Specialist Midwife - Birth Options	7	0.2
Specialist Antenatal Midwife	6	1.0
Bereavement Midwife	7	0.3
Triage Midwife	6	2.3
Triage MCA	2	1.8
Postnatal Maternity Support Workers (uplift 17.7wte from B2 to B3)	3	
Night Shift Floating Midwife	6	1.8
Total		10.1

8.8. Agreement is being sought on proposed plan to utilise the CNST Maternity incentive Scheme refund received by the Trust to improve maternity safety. Recurring posts within midwifery, obstetrics and administration include:

Recurring Investment

Investment detail	BAND	WTE
Governance Lead	8a	0.6
Quality Midwife - Obstetrics	7	1.0
Deputy Quality & Risk Midwife	6	1.0
Risk Manager - Paediatrics, Neonates & Gynaecology	7	0.2
Education & Practice Development Lead	8a	1.0
Lead Midwife	8a	1.0
Administrative Support - HOM / Consultant Midwife	4	1.0
Deputy General Manager - Obstetrics & Maternity	7	0.5
Ward Clerks - Maternity Ward, Delivery Suite & MLU's	2	6.0
Transitional Care (NICU)	5	4.1
Obstetrician	Consultant	1.0
Total		17.4

8.9. New positions funded by NHSE/I funding have been recruited to and these include: International Recruitment Midwives / Recruitment and Retention Midwives, International Recruitment Practice Educator. We are interviewing a Recruitment and Retention Project Manager which has a nominal budget to support midwifery wellbeing. These are fixed term posts with consideration to be given to permanent positions

8.10. A dedicated Professional Midwifery Advocate (PMA) role for new starters has been commenced with leadership from the Head of Midwifery via the PMA Lead

Table 5: Funded midwifery specialist and management posts July 2022 *(Source: ESR)*

Role	Band	Funded	WTE Post – Dec 21	WTE in Post – July 22
Chief Midwife/DDQN	8D	1.0	1.0	1.0
Head of Midwifery/DDQN (Gynae)	8C	1.0	1.0	1.0
Consultant Midwife(vacant)	8B	0.6	0	0
Midwifery Matrons	8A	3.0	3.0	3.8
Governance Lead	8A	1.0	1.0	1.0
Specialist Midwives	6/7	19.96	23.52	22.63
	Total	26.56	28.52	

8.11. The table below shows the range of roles required within midwifery which support meeting local, regional or national requirements. These posts are both Band 6 and Band 7 roles.

Table 6: Specialist midwifery roles *(Source: Payroll Data)*

Specialist Role - Band 6 & Band 7
Perinatal Mortality Review Midwife
Risk support midwife
TRIM practitioner
A/N Screening Advisors
Practice Facilitator
Safeguarding
Practice Facilitator - community
Frenulotomy
Breast Feeding Support
Digital Midwife
Risk Management Midwife
MSW / Apprenticeship Project
Better Births
Substance misuse/Teen preg
Practice Development Midwife
Infant Feeding Advisor
IR practice educator
Professional Midwifery Advocate Lead
International Recruitment Midwife / Recruitement and Retention Midwife
Perinatal mental health
Fetal Monitoring Midwife
Contraception Lead Midwife

Midwifery Continuity of Care (MCoC) and impact on funded establishment

8.12. NHS England (NHSE) (Oct 2021) has provided guidance to Trusts for the delivery of the MCoC programme. The roll out of MCoC will impact on the establishments as there will need to be redesigned pathways and models of care. This will impact positively upon perinatal outcomes and empowers midwives to achieve excellence in care. The approach, which is underpinned by a changing service delivery, is supported by the NHSE Midwifery Work Force Tools. The existing ~~A~~ MCoC service delivery model and business plan is being reviewed to revaluate-how we can achieve the national ambition of the MCoC model locally in light of the most recent additional guidance.

8.13. The publication of the final Ockendon report in March 2022 highlighted 15 Immediate Safety Actions of which Workforce planning and sustainability and Safe Staffing were included.

8.14. A Gap analysis against the 15 IEA's was conducted to provide an initial rapid review and reported to Q&P on the 27th of April with the following breakdown of actions related to Safe Staffing Levels which is one of the four key pillars:

Table 7: Ockendon IEA's mapping

IEA	Actions	Met	Partially met	Not Met	More Info	N/A
1. Workforce planning and sustainability	11	0	5	3	1	2
2. Safe staffing	10	4	1	4		1

8.15. Shortly after the publication of the final report, NHSE issued a clear directive to trusts on Midwifery Continuity of Carer (MCOC). In response to this we have immediately risk assessed our midwifery staffing position and made the following decisions.

- There will be no further teams launched until midwifery staffing across the service has met minimum requirements and the additional posts to support delivery of continuity of care have been fully recruited to.
- Secondly, a risk assessment has been undertaken to identify the consequences of introducing any changes to the existing 3 continuity of care teams that provide continuity of care for 10% of our most vulnerable women and birthing parents.
- Due to ongoing staffing shortages the third MCOC team has ceased with a relaunch planned when staffing stabilizes
- Continued focus on those women from vulnerable groups who will benefit the most from this care

8.16 Following the NHSE recommendation on staffing issued on the 1st of April, A commitment was made at DOAG in July 2022 by the Chief Midwife is to ensure the correct midwifery workforce in place before moving forward with further Continuity roll out. Three teams were launched in April 21 and due to recruitment and retention this has now reduced to two teams.

8.17 In line with the maternity transformation programme, we submitted our MCoC plans to NHSE/I in June 2022 which outlined a delayed rollout date with Wave 2 commencing in May 2023. The delay was initially associated with staffing levels and the implementation of the Electronic Patient Record (EPR)Maternity system Badgernet in March 2023 which has been identified as a more significant quality improvement mechanism within the service.

9. Right skills – midwifery attraction, recruitment and retention

Midwifery establishment versus actual staffing levels

9.1. The maternity service has effective strategies to attract, recruit, retain and develop our staff, as well as managing and planning for predicted loss of staff to avoid over reliance on temporary staff. This is essential as there is limited access to agency midwives in Gloucestershire

9.2. In anticipation of annual leave disproportionate to the agreed 17% due to excessive sickness, maternity leave and vacancies an incentive proposal was presented to Pay Assurance Group (PAG). Incentives within service budget included – Enhanced Bank pay rate until 31st December 2022, Temporary Standby rotas for unsocial hours

between from July until end of September 2022, and a Golden Welcome for new starters.

9.3. The Mandatory training for midwives which consists of 3 days plus e learning for midwives requires more than the Trust uplift of 21% and needs to be reviewed in line with Ockenden requirement on training and education. This will be reviewed to establish if an uplift is required following receipt of the Birthrate plus report and the finalisation of the maternity TNA

Recruitment and Retention Team

9.4. Appointments have been made following successful bids to NHSE monies to develop a team dedicated to supporting new starters and ongoing support for retaining midwives within the service. These include Band 7 12 month fixed posts of; Recruitment and Retention midwives, International Recruitment midwives, International Recruitment Practice Educator, Band 6 Dedicated Professional Midwifery Advocate (PMA) for new starters and an anticipated appointment to the Recruitment & Retention project manager

Vacancies

9.5. There are currently 21.38 WTE vacancies in the clinical workforce funded establishment.

9.6. In the past year, significant attrition has arisen from newly qualified appointees withdrawing from accepted posts prior to commencing employment with a conversion rate of 25%. To address this the HOM has negotiated a 'golden Welcome' package for new starters comprising *New Starters from August until end of Feb 2022:*

- £1000 (untaxed paid in two instalments) for staff who commence with us
- 1 year subscription to midwifery professional e-journal
- 1 year annual NMC registration fee

9.7. A regular Band 5/6 advert has seen significant interest with the recent appointment of a number of both experienced and newly registered midwifery staff. The R&R team are linking with all midwives who have accepted posts to maintain communication, outlining their role and significant support and offer the 'Golden Welcome'

9.8. To date of the 17 successful appointees, 13 have accepted the 'Golden Welcome' with start dates in September – November 2022. If achieved this would create an improved conversion rate of 76% of Band 5 and Band 6 midwives. This will be confirmed in the next Board paper.

9.9. Significant work has also been undertaken in the recruitment of Band 7 roles within the service with the creation of several new roles.

9.10. There have been a number of resignations, secondments, sick leave and short term

promotions with Band 7's across the service. Opportunities to attract current Band 6 internal applicants and external applicants through short and fixed term contracts have led to the appointment of 7.12 Band 7 manager roles between January and July 2022.

Turnover, absence and sickness

9.11. Currently there are 21.28 WTE shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

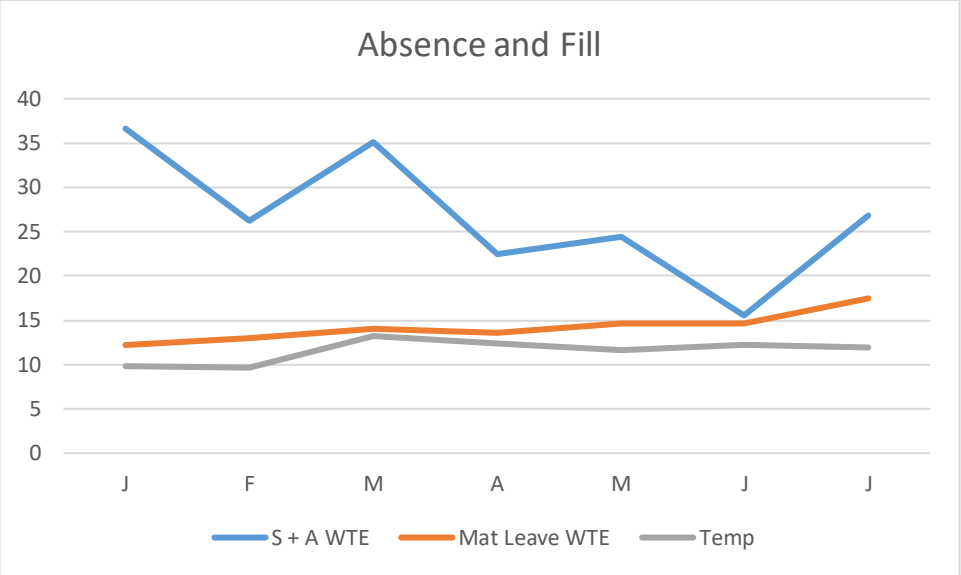
Table 8: Staffing leave/ absence and secondment *(Source: Health-Roster)*

	Sickness & Absence WTE	**Maternity Leave WTE**
Jan 2022	36.64	12.2
Feb	26.2	13
Mar	35.13	13.96
Apr	22.5	13.62
May	24.4	14.62
Jun	15.54	14.62
Jul	26.88	17.47
Aug	20.58	17.99

9.12. Peaks associated with absence were notable in January, March and July. All of these coincided with increase in Covid rates amongst midwifery staff and their families. In addition, general sickness and absence associated with mental health and anxiety were noted. Maternity leave has been consistently above 10 WTE with a peak in August of 17.99 WTE. To offset the shortfall arising from vacancies and absence, enhanced bank rates have been offered to registered midwives and this will continue until 31st December 2022. Temporary staffing fill has included both agency and bank, with agency being used for the first time within the midwifery service at the Trust. Whilst fill rate has been consistently between 10 and 15 WTE, it has not met the demands associated with midwifery absence and the vacancy rate.

9.13. The use of Bank nurses has been well received supporting midwives on the maternity ward and on delivery suite to care for high risk surgical and medical patients and fixed term roles for Band 5 nurses within maternity are being considered

Graph – Midwifery Absence and Fill rates:



9.14. In response to the poor staffing rates, actions within the service have included closure or reconfiguration of elements of the maternity service

Date commenced	Action	Duration
17th March 2022	Gloucester Birth Unit Closure	11 days
5th April 2022	Closure of Cheltenham Birth Unit	Ongoing
5th April 2022	Closure of Stroud Birth Unit	20 days
12th June 2022	Relocation of Gloucester Birth Unit to Delivery Suite	12 hours
23rd June 2022	Relocation of Gloucester Birth Unit to Delivery Suite	12 hours
14th July 2022	Whole maternity service closure	7 hours

9.15. A number of new and ongoing actions are presented monthly to the Maternity Delivery Group and those from the past 6 months listed below:

a. A Daily Head of Midwifery and Matron Staffing touchpoint
b. Band 8 of the Day embedding within the service who has overall responsibility for service wide staffing, acuity and associated actions, escalating to the Head of Midwifery if required
c. Band 7 Midwifery Managers from the in-hospital service cover the 'Flow & Quality midwife' Rota. The Flow and Quality Midwife role will support to maintain quality standards through effective staff deployment and oversight on a daily basis of the maternity service. The Flow and Quality Midwife, under the leadership and support of the Band 8 of the Day is available to provide professional leadership, guidance, development and support for midwives and support staff ensuring the provision of excellent care with compassion. The local Maternity OPEL tool is completed daily by the Flow midwife to assess staffing

and communicate activity across maternity and the wider trust

d. Use of the escalation policy; which includes the use of specialist midwives to support the clinical service, on-call midwives being called in (hospital and community) and a review of all urgent/non-urgent clinical activity.
e. A reduced Senior Midwives on-call rota with increase seniority to enhance out of hours' leadership support, including linking with Trust Site support

Temporary workforce (Agency and Bank)

9.16. The maternity service continues to use limited selected agency midwifery and nursing bank to fill shifts where there are shortages of staff. A bespoke nursing bank pool is being developed for the maternity ward. Enhanced bank rates have increased fill rates.

9.17. However, even with agency and bank usage in every month there were approximately 300 unfilled Registered Midwife shifts. That is approximately 70-90 **unfilled midwifery shifts** per week and this continues to have an impact on the midwives' wellbeing and the safety of the service. During July 2022, there were 397 Bank and agency shifts completed across all areas in maternity.

Midwifery leadership

9.18. Each clinical area has a defined midwifery lead providing professional leadership, clinical expertise and managerial responsibility ensuring effective use of staffing resource and safe delivery of care to women accessing the service.

9.19. In addition, the central delivery suite is funded to have a supernumerary Band 7 shift coordinator allocated to each shift to provide professional leadership, clinical expertise and will have responsibility for the shift; this individual should have detailed knowledge of activity on the delivery suite supplemented by an awareness of activity within the inpatient areas and pending admissions from outpatient and triage areas. The Band 7 Flow and Quality Midwife role has been introduced. This 'helicopter view' is essential for overall assessment of the acuity and to support staff redeployment when required.

9.20. The newly established 'Flow and Quality' Midwife role is embedding. This is a Band 7 midwife who supports the 'Band 8 of the day' and Delivery Suite co-ordinator to manage flow associated with staffing and activity throughout the service. Currently covering Monday to Friday. The impact of the role has been very positive with consideration of 24/7 role:

> the introduction of the flow midwife has had a significant and positive impact to busy shifts,
>
> I think the introduction of the daily Band 7 'flow' midwife would help with this (mon-fri anyhow) in terms of the amount of time it takes to coordinate a transfer. I have found them really useful of late whilst on call in terms of ring other units for potential IOL transfers and sorting the ' leg work' when the elcs list needs to be jiggled (sorting TTOs, changing pre-op etc) A welcome change from me.

9.21. The Band 7 CDS co-ordinator is supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. The shift coordinator is responsible for liaising with all areas to ensure safe and effective use of resources to

ensure safe delivery of care at all times.

9.22. The responsibility for addressing known midwifery staffing shortfalls rests with the Senior Band 7 who has responsibility for managing the area. When staffing shortages remain an issue on a day to day basis this is escalated to the “Band 7 Flow & Quality Midwife” or “Band 8 of the day”.

9.23. Further actions in response to staffing shortfall over the past 6 months have been a feature of managing the service based on midwifery availability.

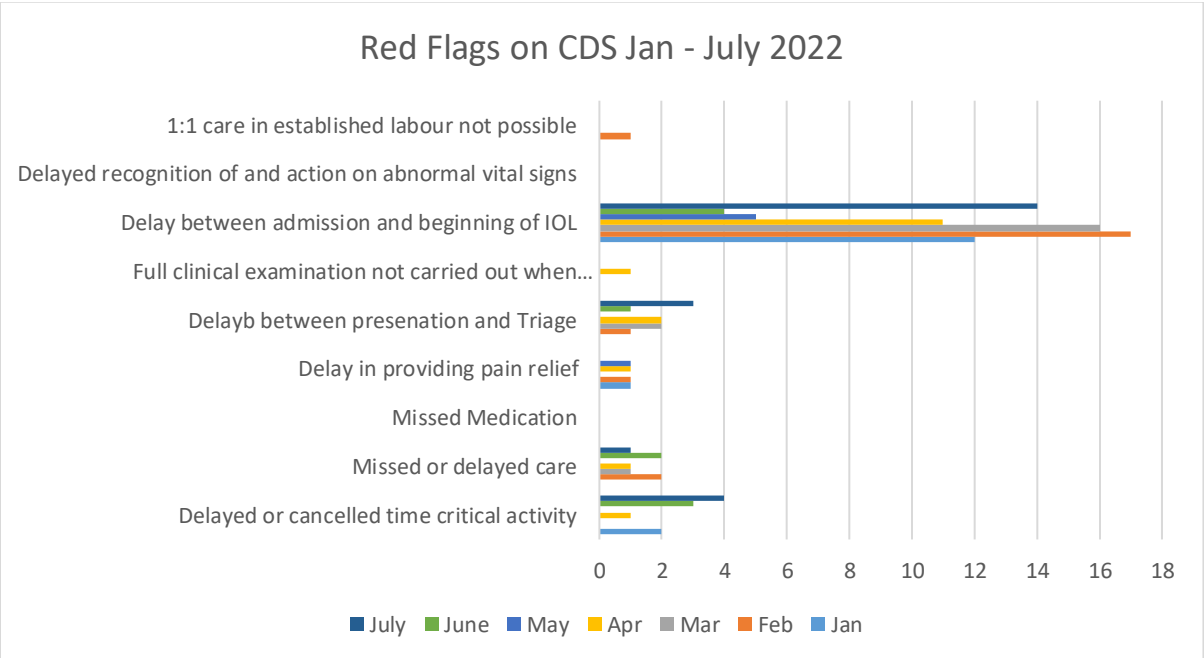
9.24. To note that whilst there was an increasing number of Midwife in charge (Band 7) unfilled shifts in the previous 6-month period, this has significantly reduced. The Band 7 team are fully recruited to. This supports the level of oversight and change required at this current time. During the period where there were vacancies, ‘temporary uplift posts’ were recruited to for 3-month period. This has led to successful recruitment to permanent and 1 year secondments for local Band 6 midwives into Band 7 roles.

<u>Safer Midwifery Staffing</u>

9.25. <u>Ongoing monitoring of safety metrics and data</u>

- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- We use the Birthrate+ Acuity tool which monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.

Table 9: BR+ Review of Red Flags Jan- July 2022 *(Source: Birthrate plus)*



9.26. There was one reported episode in February 2022 where 1:1 care in labour was not possible on CDS. This source is Birthrate plus. The most frequent Red Flag was associated with delays in Induction of labour. There was a range of between 4 and 17 episodes a month.

9.27. 1:1 care in labour is monitored at Quality & Performance and reported monthly. Data Is acquired from Trakcare and discrepancies are analyzed by the Digital Midwife. An action plan specifically related to 1:1 care in labour was implemented following the Section 29a and is monitored by the Divisional Tri.

Table 10: 1:1 Care in labour compliance *(Source: Trakcare)*

Month	1:1 care in labour compliance
Jan	96%
Feb	95%
Mar	95%
Apr	99%
May	98%
Jun	99%
July	96%

9.28. Accepted midwife to birth ratio is 1:28. Midwife to birth ratio has been calculated monthly to provide actual ratio based on: Establishment – vacancies – absence (Sickness & absence + mat leave) + Temporary Staffing = Actual Midwife. The (Monthly Births x 12)/ Monthly Actual Midwife = comparative monthly figure to illustrate fluctuations in ratio as presented below. The data is presented following alignment of locally held data.

Table 11: Midwife to Birth Ratio *(Source: ESR/Health Roster)*

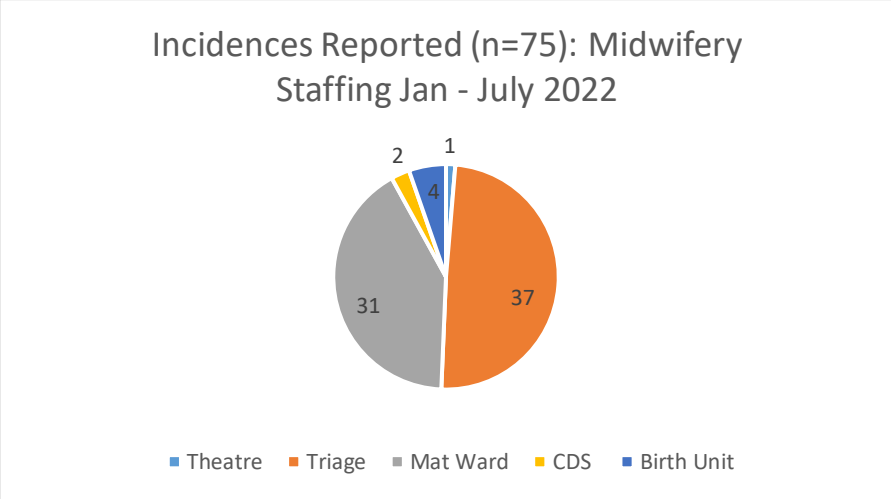
Month	**Midwife to Birth Ratio**
Jan 2022	1:33
Feb	1:27
Mar	1:32
Apr	1:27
May	1:28

Month	Midwife to Birth Ratio
Jun	1:28
July	1:31

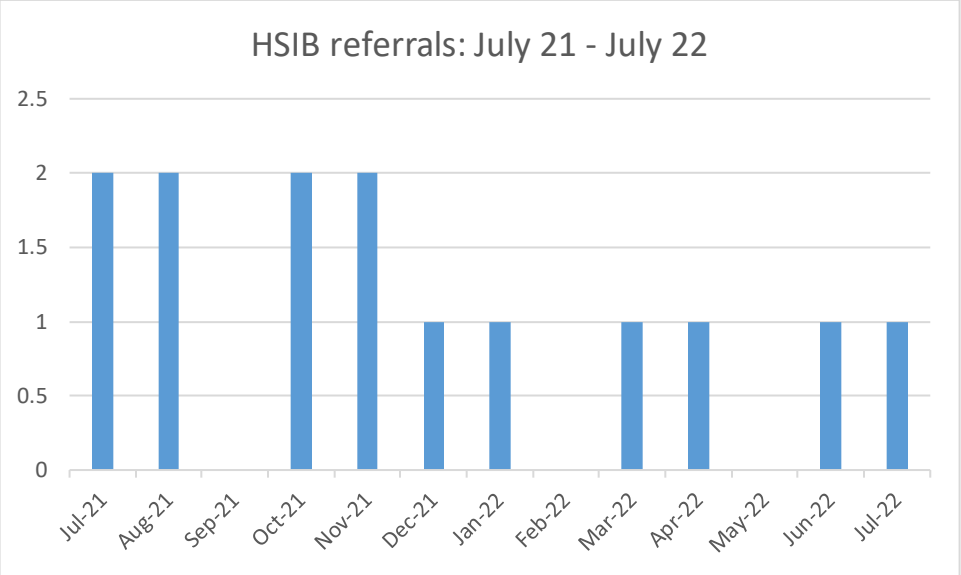
This is monitored via the Divisional Dashboard at the Maternity Clinical Governance Meeting and Divisional Board. The table above illustrates an improved Midwife to Birth ratio in February, April, and June. This is associated with a reduction in sickness and absence rates within midwifery.

9.29. During the months of January to July there were 75 Datix incidences reported related to midwifery staffing. The majority of these related to insufficient staffing in Maternity Triage. This relates to Risk Register entry number WC3685Obs. The next most significant area involved Maternity Ward.

Graph: Incidences associated with staffing



9.30. HSIB referrals are monitored via the maternity dashboard. During the period of July 21 – December 2021 the HSIB referrals did not exceed 2 per month, with a total of 9 cases. During the period of Jan 22 – July 2022, the picture improved. HSIB referrals did not exceed 1 per month with a total of 5 during the subsequent 6-month period:



Escalation and Trust risk register entry

9.31. Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.

9.32. Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet women's and babies' needs.

9.33. The risk associated with midwifery staffing (**W&C3536OBS)** remains on the Trust Risk Register (score 15 for safety). An improvement action plan was developed.

9.34. This has now been followed by a prospective Retention and Recruitment plan for 2022 with key areas being prioritised to support workforce growth and development including:

- Retention lead posts
- Midwifery development and leadership
- Emotional wellbeing project
- Development of Maternity Support Worker role

9.35. Day to day management of the suboptimal staffing is being managed by increased, visible midwifery leadership in key areas. A daily and weekly service wide overview of staffing has been implemented to enable oversight and planning ahead for staffing issues. In addition, responsive Multidisciplinary Huddles which includes the Service Tri are conducted on CDS during periods of significant activity.

10. Right skills – mandatory training, development and education

10.1. Our staffing establishments take account of the need to enable clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students. The CQC 29a warning notice was received in June 2022 in response to not complying with legal requirements on minimum staffing

10.2. The service has identified the need to expand Administrative and clerical roles to release midwifery time. A paper has been submitted to the clinical safety group.

10.3. In the past year due to the pandemic and surges of Covid-19 mandatory and non-mandatory training has been either cancelled or staff asked to attend clinical areas and rebook onto other dates which has impacted on our mandatory training compliance rates. **Mandatory training compliance has decreased from 81% in December 2021** (Trust target 90% compliance). Significant work is underway to increase MDT compliance with mandatory training across all staff groups to achieve 90% by the 31st December 2022. The 90% compliance is a Maternity Incentive Team requirement for all staff.

Table 12 – Mandatory Training Compliance – All Staff groups – July 2022
(Source: Local Training Data)

Training Detail	Midwives	Obstetricians	Anaesthetists	Theatre Teams
Mandatory Midwives Day	65%	NA	NA	NA
PROMPT Theory	80%	74%	58%	
PROMPT Skills	75%	70%	45%	58.6%
Fetal Monitoring	58%	37%	NA	NA

10.4. A recovery plan has put in place with additional training dates so that compliance can be met by end of December 2022.

10.5. Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.

10.6. Over the last few months due to the pandemic and surges of Covid-19 **appraisal rates have decreased from 68% in December to 60% in July** (Trust target 90%

compliance). A recovery plan is being put in place with additional training dates so that compliance can be met by end of December 2022. This forms part of the CQC 'Must Do's'

10.7. The appointment of the Organisational Development Lead post which commenced in August 2022 is supporting the overall midwifery compliance with appraisals.

10.8. The maternity service analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework. The maternity service Practice Development team will complete a Training Needs Analysis exercise to ensure that all six core modules of the Core Competency Framework are included in our unit training programme over the next 3 years (NHSR, MIS safety action 8). The training plan will include;

- Saving Babies Lives Care Bundle
- Fetal surveillance in labour
- Maternity emergencies and multi-professional training.
- Personalised care
- Care during labour and the immediate postnatal period
- Neonatal life support
- Local learning from incidences

This TNA will be completed by the end of October 2022 in readiness for January 2023 commencement.

11. Conclusions

11.1. The data within this report provides assurance that there are effective workforce planning tools being used currently to review current establishments. This report describes the urgent action being taken to tackle the staff shortages and the increased pressures this has on staff, which have been exacerbated by the Covid-19 pandemic.

11.2. Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. HSIB referrals have decreased in this 6-month period. Initiatives to enhance recruitment and retention are being actioned and it is anticipated that the next 6 months will see an improved recruitment picture. Attrition continues to be of significant concern and actions to address this are ongoing.

11.3. It is recognised that staffing shortages increase pressure on the workforce across the whole service leading to high levels of stress. Workforce shortages are being regularly monitored on a shift-by-shift, weekly and monthly basis. Colleague wellbeing initiatives have been put in place for staff to access, as required, through the service and also through the 2020 Staff Advice and Support Hub.

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1:1 care in labour – action plan (extracted from CQC 29a overarching action plan)

V1.7 – shared with CQC on the 7th October

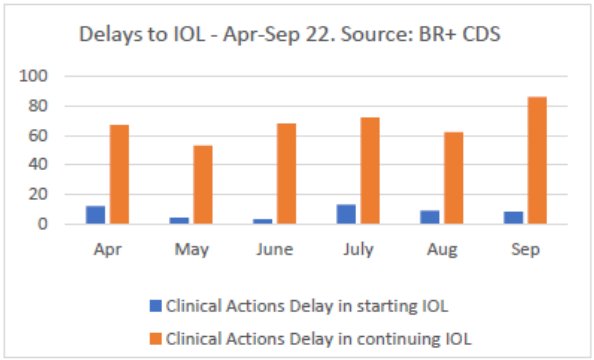
Gloucestershire Hospitals NHS Foundation Trust (RTE)
Care Quality Commission inspection 2022
S29a Required significant improvements - Maternity and Midwifery Services

												Jul-22	Aug-22	Sep-22				
Reference number	**Number**	**Required Significant improvements**	**Core Services**	**Site**	**Regulation breach**	**Responsible lead**	**Executive lead**	**Operational Delivery**	**Assurance**	**Areas requiring improvement**	**Summary Actions**	**19th July Update**	**19th August Update**	**End of September Update (5th October)**	**Action Owned by**	**Due Date**	**BRAG Rating**	**Evidence reference**
3.2	**3**	There are governance systems and processes, but they do not work effectively to ensure the oversight of the service and to learn from incidents and improve practice to keep service users safe within Gloucestershire maternity services.	Maternity and Midwifery Services	All	29a	Vivien Mortimore / Lisa Stephens	Matt Holdaway	Maternity delivery group (MDG)	Quality & Performance / LMNS	You are unable to demonstrate that one-to-one care in labour is being provided for all women across the maternity service. Data submitted from the electronic patient record system, TRAK shows one-to-one care was provided for 95% women in February 2022 and March 2022. You record one-to-one care on the birth-rate plus acuity tool, but this data entry does not include the standalone birth centres in Stroud and Cheltenham, or home births. You commented that the data for the midwife led Gloucester birth unit does not consistently meet the confidence factor of over 70%. One-to-one care in labour is required to ensure the health and safety of women and their unborn baby or babies is assessed, monitored and supported throughout labour. This requires significant improvement to ensure you are assured one-to-one care in labour is being achieved and are able to identify and respond to occasions when this support is not achieved.	Establish single rota for midwives	Consolidate on-call rotas onto health roster - all staff rostered and on call rota's to be held via rostering system. Due to be implemented in September		Unit of call is now on healthroster. Community rotas not able to use electronic system but key rotas now included.	JJ / JC	30-Sep-22	G	
											Improve recording of 1:1 care in labour	Review of data from April 22 to date showed that 74% of births with no 1:1 care recorded were Caesarean births (Cat 1-4). 1:1 sessions with senior leads have taken place to focus on correct data entry / compliance. Monthly reporting to HoM to review data and track improvements, enable targeted comms.	BR+ data for May, June & July 2022 indicates that there were no occasions when one-to-one midwifery care and support was not provided during established labour on CDS. Data for all other areas is captured on TrakCare, we recognise that there are data quality issues as this is not currently a mandatory field for areas outside of CDS. Data reported via Trak Care: April - 98% May - 97% Jun - 97% Jul - 96% We believe this to be a data quality issue and are running data and quality checks. Our Qualitative data suggests a combined performance of 98-99%..	August data from TrakCare 96% Delivery suite BR+ data 100% compliance - there were no occasions when one-to-one midwifery care and support was not provided during established labour on CDS.	AL	30-Nov-22	G	GHFTCQC_008_CDS_BR+_IOL_1-1
											Improve data capture for elective Caesareans	Good practice examples have been highlighted and shared. Specific guidance on recording has been posted in recovery to aid completion / clarify definitions. Advice on how to escalate where 1:1 care has not been achieved has also been shared.			Jo Crisp	31-Oct-22	G	
											Establish escalation process for where 1:1 care has not been achieved		Updated SOP launched which reflects the requirement to escalate to both band 8 of the day and senior unit midwife if 1:1 labour cannot be achieved.	As per SOPs Datix to be submitted where 1:1 labour cannot be achieved. 0 incidents reported since implementation of SOP	LS	11-Aug-22	B	

Additional information shared as appendix GHFTCQC_008_CDS_BR+_IOL_1-1

Delays to Induction of labour (IOL) where 1:1 care in established labour not possible - Data source BR+ Central Delivery Suite

	Clinical Actions		Red Flags
	Delay in starting IOL	Delay in continuing IOL	1:1 care in established labour not possible
Apr	12	67	0
May	4	53	0
June	3	68	0
July	13	72	0
Aug	9	62	0
Sep	8	86	0



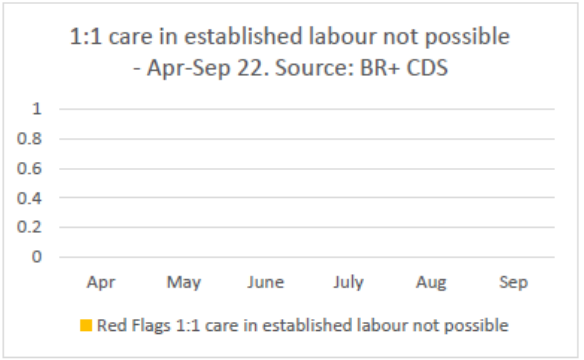


Table: Maternity Incentive Scheme	
Safety action 1: National Perinatal Mortality Review Tool	The Board are asked to note that this report includes details of the deaths reviewed and the consequent action plans. The report provides evidence that the PMRT has been used to review all eligible perinatal deaths and that the required standards have been met (100% for each area). These reports will be shared with the Maternity and Neonatal Safety Champions and members of the Maternity Delivery Group.
Safety action 2: Maternity Services Data Set (MSDS)	Our MSDS report will be published on 27 October 2022 and will be included in the next Board update to show our compliance and if we do not reach the standards then an action plan will be provided. The Maternity Digital strategy will be signed off by ICB/LMNS and will be included for information in the Q3 report.
Action 3 Transitional Care Services in place	Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion at the Maternity Delivery Group. To meet the standards the Chief Nurse will need to share at ICS Quality Surveillance meeting.
Action 4 Workforce planning in place to the required standards	The Board are asked to note the Consultants' engagement with the RCOG Roles and Responsibilities document. Audits monitoring compliance of consultant attendance for the listed clinical situations when a consultant is required to attend in person have begun and results are being reviewed (83% when called). We ask that it is recorded that the Trust meets the BAPM national standards for junior medical staffing. The neonatal unit meets the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed on the 14/03/2022. The neonatal unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines.
Action 5 Midwifery workforce planning in place	Currently a BirthRate plus (BR+) full review of midwifery staffing has been completed and the report is due in the autumn 2022. We are 100% compliant with supernumerary labour ward co-ordinator status Our provision of one-to-one care in active labour is not yet at 100% because of data quality issues and we have included a data improvement plan which we ask the Board to approve.

Action 6 Saving babies lives care bundle (SBLCBv2)	The quarterly care bundle surveys are being completed and the service has fully implemented SBLv2 including the data submission requirements. Our current data does not meet target compliance in elements 1-4 we are not meeting the minimum requirements and no action plans have been received by MDG. An action plan will be submitted to the next MDG. Element one • Carbon Monoxide (CO) measurement at booking is recorded and 36 weeks is recorded. Element two • Risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan Element three • Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. • Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Element four • Staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. Element five • Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. • Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. • Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. • Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).
Action 7 Service user feedback and work with MVP to coproduce maternity services	Patient experience plan
Action 8 Local training plan in place to meet all 6 core modules of the core competency framework	• **Training compliance decreased to 62% (compliance target is 90%).** • Training compliance to be 90% by 5th Dec 2022 (CNST will measure compliance over any 12 month period between August 21 and 5th Dec 22). The Trust are utilising data 23rd Nov 2021 – 23rd Nov 2022
Action 9 Maternity Safety Champions	• Out to recruitment for Maternity and Neonatal Safety Champions who are direct care staff. • Monthly meetings going ahead. • Engagement event in the neonatal unit.
Action 10 HSIB and NHSR reporting	Compliant with reporting.